



NYC

EMPLOYEE

BENEFITS

PROGRAM

1991

HEALTH BENEFITS
SUMMARY PROGRAM
DESCRIPTION



THE CITY OF NEW YORK OFFICE OF LABOR RELATIONS
EMPLOYEE BENEFITS PROGRAM



THE CITY OF NEW YORK
OFFICE OF THE MAYOR
NEW YORK, N.Y. 10007

October 1991

Dear Health Benefits Recipient:

Employee benefits are important to all of us, and the City of New York is committed to providing adequate health care protection to all of its employees. This is, however, expensive and controlling these costs is the responsibility of all concerned - employees, retirees, municipal unions and the City of New York.

Benefits provided to you and your families are collectively bargained with the municipal unions who play a role in determining the amount of funds available, the scope of benefit plans and even what plans are offered.

Only with the combined continued effort of all can we preserve current levels of benefits and provide for future improvements.

Your contribution towards controlling health care costs can be accomplished by becoming an informed consumer of health care services and by taking responsibility for your own health through healthier living.

This booklet contains important information about the City's health benefits program, such as who is eligible, and how to enroll. It also describes the specific benefits available under each of the health plans offered to City of New York employees, retirees, and their dependents.

Most or all of the cost of the available health benefits plans is paid for by the City of New York, but please take the time to read the booklet carefully; the plans and their costs do differ. You should consider which plan best meets your needs and those of your family.

My best wishes for your good health.

Sincerely,


David N. Dinkins
MAYOR

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INTRODUCTION

Through collective bargaining agreements, the City of New York and the Municipal Unions have cooperated in designing the benefits for the City's Employee Benefits Program. These benefits are intended to provide you with the fullest possible protection that can be purchased with the available funding.

The City's Employee Benefits Program provides health benefits to approximately one million people and has annual premiums over one billion dollars—making New York City the largest purchaser of employee health services in the Greater New York area. Administered by the Mayor's Office of Labor Relations, the Employee Benefits Program continues to receive a strong Mayoral commitment to provide the finest available health care coverage.

Employees and retirees may choose from the following plans:

- CIGNA HEALTHPLAN (formerly TOTAL HEALTH)
- Group Health Incorporated—Comprehensive Benefits Plan/
Empire Blue Cross and Blue Shield (GHI-CBP/EBCBS)
- Group Health Incorporated—Type C/Empire Blue Cross and
Blue Shield (GHI Type C/EBCBS)
- Empire Blue Cross and Blue Shield HEALTHNET
- Health Insurance Plan of Greater New York/Health Maintenance
Organization (HIP/HMO)
- HIP CHOICE
- Med Plan (New enrollments or transfers must be HHC employees
or non-Medicare eligible retirees)
- Med-Team (DC 37 members only)
- Metropolitan Health Plan (HHC employees and non-Medicare
eligible retirees only)
- Mid-Hudson Health Plan
- SANUS HEALTH PLAN
- US HEALTHCARE
- WellCare

This "Summary Program Description" booklet gives brief plan descriptions and a comparison of benefits of all available plans. It also provides important general information about the Employee Benefits Program. You will receive an in-depth description of the plan you have chosen from your health plan after you enroll.

We urge you to read this booklet carefully and use the benefits wisely.

The 1991 Transfer Period will take place from October 1 to October 31, 1991, and will be open to all employees.

All transfer applications must be submitted by October 31, 1991.

CHOOSING A HEALTH PLAN

To select a health plan that best meets your needs, you should consider at least four factors:

1. **COVERAGE:** The services covered by the plans differ. For example, some provide preventive services while others don't cover them at all; some plans cover chiropractic services and routine podiatric (foot) care, while others don't.
2. **CHOICE OF DOCTOR:** Some plans provide partial reimbursement when non-participating providers are used. Other plans only pay for or allow the use of participating providers.
3. **ACCESS:** Certain plans may have participating providers or centers that are more convenient to your home or work-place.

4. **COST:** Some plans require payroll and pension deductions for basic coverage. The cost of Optional Riders also differs. (These costs are compared on charts at the end of this booklet.) Some plans require a small copayment for each routine doctor visit. Some plans require you to pay a yearly deductible before the plans will reimburse you for the use of non-participating providers. If a plan does not cover certain types of services that you expect to use, you must also consider the out-of-pocket cost of these services.

If you want further information on benefits, participating doctors, office locations, etc., call the plans you are interested in directly. Telephone numbers are listed at the end of each plan description.

DEFINITIONS

The following explanations of terms will help you understand what you will be reading in this booklet.

Coinsurance

The portion, generally a percentage, of the covered expenses approved by the health plan that is not paid by the plan. Covered expenses are generally less than actual submitted charges. (Example: GHI-CBP pays 80%, after the deductible, of a covered expense. The remaining 20% is the coinsurance.)

Copayment

A fixed amount of money that the patient must pay, which is a part of the cost for certain services provided by his/her health plan (Example: \$3 WellCare copayment for a routine medical checkup in a doctor's office).

Covered Services

Services for which the health plan will pay either partially or in full.

Deductible

An initial payment for medical services for which patients are responsible before their health plan will begin to pay for services. (Example: HIP CHOICE yearly deductible of \$200 per covered person; \$400 per family).

Eligibility

Eligibility for health coverage for employees, retirees and dependents is defined in Section Four, paragraph B.

Health Maintenance Organization (HMO)

An organized system of health care that provides hospital and medical services to its members. Individuals and/or families who choose to join a particular HMO can receive health care at little or no out-of-pocket cost provided they use the HMO's doctors and facilities. HMO members choose a family physician (participating provider) from within their HMO network, and they must go through this physician for all medical services, referrals and non-emergency hospitalizations. If a physician outside of the health plan is used without a referral from an HMO, the patient is responsible for all bills incurred.

Individual Practice Association (IPA)

A group of independent doctors who provide services to HMO members while maintaining their private practice.

Managed Care

Review, by physicians and other specially-trained professionals, of proposed hospital admissions and certain outpatient procedures. This helps ensure that only medically necessary services are used, and that they are rendered in the most appropriate setting.

Medicare Risk Plans

Medicare subscribers enrolled in Medicare Risk Plans can ONLY receive services through their health plan. This means that if they use services outside of their plan, Medicare will NOT pay for them, nor will they be paid for by the plan. (US HEALTHCARE, HIP VIP, and CIGNA HEALTHPLAN have Medicare Risk Plans.)

Non-Participating Provider Benefits

The portion of your health plan that partially reimburses you for health care services received from non-participating doctors. You must pay these doctors directly. Reimbursement to you is subject to annual deductibles and coinsurance. The amount to be reimbursed for any procedure is either based on a scheduled amount or on reasonable and customary charges. (GHI-CBP/EBCBS, HIP CHOICE, DC37 Med-Team.)

Out-of-pocket Expenses

Payments for services made directly by the patient; such expenses are not reimbursed.

Paid-in-full Benefits

Benefits which are not paid for by the patient. They are paid for by that patient's health plan.

Participating Providers

Medical providers who accept payment directly from health plans. The patient pays a small copayment, or nothing at all, when using these providers. Each plan provides members with a list of participating providers.

Primary Care Physician

A general practitioner, internist, family practitioner, or pediatrician who handles your health care needs and those of your family. He or she determines the nature and severity of health problems and recommends treatment approaches. A primary care physician not only provides a broad range of preventive and treatment services, but also makes referrals to specialists, or for tests, and integrates the results of these referrals into your overall treatment plan.

Reasonable and Customary Charges

A schedule, generally based on a survey or formula, of physician fees for specific medical and surgical procedures that are commonly charged in a defined geographic region.

SECTION ONE

RECENT BENEFIT CHANGES

Medical Spending Conversion (MSC)

As of October 1, 1991, all employees will be eligible to increase their take-home salary. New York City is implementing Medical Spending Conversion (MSC) in accordance with Internal Revenue Code Section 125, as the first phase of the City Flexible Spending Plan. MSC is a program that allows all New York City employees (as well as employees of agencies covered by City health plans), who make payments for basic and/or optional benefits to contribute to their health benefits cost on a pre-tax basis. This pre-tax contribution effectively reduces the salary on which taxes are computed by the amount of the MSC payment. The amount of savings in take-home salary will depend on the health plan option and whether there is individual or family coverage. The overall reduction in gross salary will be shown on the W-2 form at the end of the year. Therefore, MSC will not change the gross salary on employees' paychecks.

What other effects will MSC have, besides tax reduction?

a) Pension. The MSC will have no effect on pension payments or benefits. For the calculation of pensionable salary, an employee's salary will continue to be defined as the unadjusted gross income (i.e., before the health premium deduction). **b) Social Security.** There will be a savings on Social Security due to the MSC. However, Social Security retirement benefits will be slightly reduced. The effect will be minimal and will be offset by the amounts saved in taxes today. For example, an individual aged 55 earning \$35,000 per year who contributes \$500 per year in pre-tax health plan contributions beginning in 1988 would experience an annual reduction of approximately \$23 in the Social Security benefit at age 65. **c) Deferred Compensation.** MSC may affect contributions to the Deferred Compensation Plan. The decrease in taxable gross income will reduce the contributions that are based on a percentage of salary. In other cases, individuals earning less than \$21,250 may already be eligible for a health insurance tax credit to offset income

taxes by up to 100% of the cost of health insurance that covers at least one qualifying dependent child. Individuals who intend to take advantage of this tax credit must decline the Medical Spending Conversion benefit.

Since enrollment in MSC is automatic, a Declination Form must be completed. This Form is obtainable at payroll offices.

For more information concerning the MSC benefit, refer to the Medical Spending brochure.

CIGNA HEALTHPLAN

TOTAL HEALTH has changed its name to CIGNA HEALTHPLAN of New York. Benefits of the Plan remain the same.

GHI-CBP/EBCBS

Effective July 1, 1991:

- The GHI coverage for emergency ambulance service has been increased to up to \$100 for each ambulance trip.

Effective July 15, 1991:

- The GHI copayment for home and office visits is increased to \$10, and now also applies to out-of-hospital specialist consultations.
- EBCBS coverage for in-hospital psychiatric care admissions is limited to 30 days. In an approved general hospital, GHI provides coverage for up to 9 half-days if the subscriber is not covered by an EBCBS rider. Coverage in psychiatric hospitals, which is not covered by EBCBS, continues to be covered by GHI to an annual maximum of \$10,000 or 30 days, whichever is reached first.
- GHI coverage for routine foot care is discontinued, except as prescribed for a metabolic disease such as diabetes.
- Visits for chiropractic care are limited to eight per calendar year. Visits made from January 1 to July 15, 1991 will count toward the 1991 8-visit maximum unless GHI had already approved an extended treatment plan (in which case up to an additional 4 visits will be covered), not to exceed the total number of approved visits.
- Hospital confinements for medical rehabilitation/physical therapy covered by GHI are subject to a 30-day maximum per calendar year. Coinsurance, deductibles, and maximum are unchanged.
- Private Duty Professional Nursing services are subject to a separate GHI deductible of \$250 per person per calendar year.

Effective August 1, 1991:

- An inpatient EBCBS deductible of \$200 per admission (\$500 per person per calendar year maximum) is established. Readmissions within 90 days count as the same admission. When admission results in childbirth, the child is not considered separately admitted, and will not be charged a deductible.
- Hospital charges for outpatient treatment are reimbursed at 80% of approved reimbursement by EBCBS. The subscriber is responsible for 20% of the charges up to \$200 per person in a calendar year.

(NOTE: These deductible and coinsurance charges are not covered as excess hospital benefits under GHI.)

Effective October 1, 1991:

- \$10 copayments will be applied for diagnostic services performed by GHI participating providers.
- A GHI preferred provider panel is being established to supply durable medical equipment (subject to a separate annual deductible of \$100 per person). There will be no out-of-pocket expense to you other than the deductible. If you obtain durable medical equipment from other than preferred providers, GHI will reimburse you 50% of the allowed charges.

Effective January 1, 1992:

- The GHI annual deductible applied to covered services received from non-participating providers will increase from \$135 per person/\$400 per family, to \$175 per person/\$500 per family.
- GHI medical coverage for dependent students ages 19-23 will be available only through the Optional Rider.

HIP/HMO

Effective January 1, 1992, HIP has added the following benefit to its HIP/HMO plan.

Routine Footcare - up to 4 visits per year provided by HIP at the member's HIP medical center.

HIP VIP

Effective March 1, 1991, a \$2.50 copayment is required for covered prescriptions (30 day supply) written by HIP physicians and filled at HIP participating pharmacies.

SECTION TWO

IF YOU NEED ASSISTANCE

Retirees

Retirees with questions about benefits, services, or claims should write or call their health plan at the address given either in this booklet or the appropriate plan booklet. When writing to the Plan, give your Social Security Number, Certificate Number (if different), Group Number, name and address. The Employee Benefits Program is also available to provide service and information to City retirees who have questions about or problems with their health benefits or pension check deductions. Retirees writing to the Employee Benefits Program should always include the following information:

- name of health plan
- certificate number/identification number
- Medicare claim numbers
- names and dates of birth of yourself and your dependents
- your telephone number, pension number and pension system
- the name of the City agency from which you retired
- your last Civil Service Title
- the name of your union or welfare fund (if any)
- the health code or the amount currently being deducted from your pension check
- date of retirement

You can contact the Employee Benefits Program at:

City of New York Employee Benefits Program
40 Rector Street—3rd Floor—New York, NY 10006
(212) 513-0470

Employees

Employees may direct questions concerning enrollment or paycheck deductions to, or obtain application forms (EB 88) from their worksite agency personnel or payroll office. If assistance is not available at your worksite, please refer to the listing for your agency health benefits office telephone number. Employees with questions relating to benefits, services, or claims should write or call their health plan at the address given in either this booklet or the appropriate plan booklet. When writing to a plan, give your Social Security Number, certificate number (if different), group number, name and address, date(s) of service, and claim number(s), if applicable.

Agency Benefits Representatives (for employees only. Retirees, see previous page.)

CITY AND CITY-RELATED AGENCIES

Actuary, Office of the
(212) 566-0631
Addiction Services Agency
(See Health, Dept. of)
Aging, Dept. for the
(212) 577-1715
Air Resources, Dept. of
(See Environmental Protection Administration)
Art Commission
(See Mayor, Office of the)
Borough President – Bronx
(212) 590-3531
Borough President – Brooklyn
(718) 802-3823
Borough President – Manhattan
(212) 669-8006
Borough President – Queens
(718) 520-3213
Borough President – Staten Island
(718) 390-5182
Buildings, Dept. of
(212) 312-8258
Business Services, Dept. of
(212) 513-6317, or (212) 806-6767
Campaign Finance Board
(212) 306-7138
Chief Medical Examiner
(See Health, Dept. of)
City Clerk
(212) 669-8097
City Council, Office of the
(212) 566-7227
City Council, President of the
(212) 669-7652
City Planning, Dept. of
(212) 720-3683
City Record
(See General Services, Dept. of)
City Register
(See Finance, Dept. of)
City Sheriff
(212) 374-8228
City University of New York
(See separate listing)
Civil Service Commission
(212) 248-8306
Collective Bargaining, Office of
(212) 306-7182
Commerce & Industry, Dept. of
(See Economic Development, Office of)
Community Assistance Unit
(212) 566-1465
Comptroller, Office of the
(212) 669-7792
Computer Data Communications Services Agency
(212) 240-4327
Consumer Affairs, Dept. of
(212) 206-3235
Correction, Board of
(212) 964-6307
Correction, Dept. of
(212) 374-7628, 7627
Cultural Affairs, Dept. of
(212) 841-4187

Cultural Institutions
(See separate listing)
District Attorney – Bronx County
(212) 590-2538
District Attorney – Kings County
(718) 802-2996
District Attorney – N.Y. County
(212) 335-9847
District Attorney – Queens County
(718) 520-5539
District Attorney – Richmond County
(718) 390-2635
Districting Commission
(212) 766-2224
Education, Board of
(718) 935-2312
Elections, Board of
(212) 487-5329
Employment, Department of
(212) 433-3876
Environmental Protection, Dept. of
(718) 595-3373
Estimate, Board of
(212) 669-4512
Ethics, Board of
(212) 566-4902
Ferry & General Aviation Operations, Bureau of
(See Transportation, Dept. of)
Finance, Dept. of
(212) 669-4457
Financial Information Services Agency
(212) 206-3235
Fire Dept., (Uniformed Forces)
(718) 403-1586
Fire Dept., (Non-Uniformed)
(718) 403-1587
Firearms Control Board
(212) 374-5550
Franchises, Office of
(212) 669-4500
General Services, Dept. of
(212) 669-7265
Handicapped, Office for the
(See Mayor, Office of the)
Health Dept., Office of Administration
(212) 566-6624, 6625
Health and Hospitals Corporation
(See separate listing)
Highways, Dept. of
(See Transportation, Dept. of)
Housing Authority
(212) 306-8096
Housing Preservation & Development, Dept. of
(212) 978-6794
Human Resources Administration
(212) 274-3594
Human Rights, Commission on
(212) 306-7541
Investigation, Dept. of
(212) 825-2162
Juvenile Justice, Dept. of
(212) 925-7779, ext. 307
Labor Relations, Office of
(212) 306-7260
Landmarks Preservation Commission
(212) 553-1100

Law Department
(212) 788-0320
Licenses, Dept. of
(See Consumer Affairs, Dept. of)
Management & Budget, Office of
(212) 788-6097
Markets, Dept. of
(See Consumer Affairs, Dept. of)
Mayor, Office of the
(212) 788-2680
Mayor's Office of Special Events
(See Mayor, Office of the)
Mental Health, Dept. of
(212) 431-3731
Municipal Broadcasting System
(See General Services, Dept. of)
Municipal Reference Library
(See General Services, Dept. of)
N.Y.C. Employees' Retirement System
(212) 566-4548
Off-Track Betting Corp.
(212) 704-5883
Parking Violations Bureau
(See Transportation, Dept. of)
Parks & Recreation, Dept. of
(212) 830-7771
Personnel, Dept. of
(212) 566-8746
Police Department
(212) 374-7654
Probation, Dept. of
(212) 374-3796
Prosecution, Office of
(212) 815-0515
Public Administrator, Bronx County
(212) 293-7660
Public Administrator, NY County
(212) 374-8266
Public Works, Dept. of
(See General Services, Dept. of)
Purchase, Dept. of
(See General Services, Dept. of)
Real Estate, Dept. of
(See General Services, Dept. of)
Real Property Assessment, Dept. of
(See Finance, Dept. of)
Records & Information Services, Dept. of
(212) 566-1597
Rehabilitation Mortgage Ins. Corp.
(212) 425-9351
Sanitation, Dept. of
(212) 815-9867
School Construction Authority
(718) 472-8063
Social Services, Dept. of
(See Human Resources Administration)
Special Narcotics Court
(212) 815-0526
Standards & Appeals, Board of
(212) 807-3723
Tax Collection, Dept. of
(See Finance, Dept. of)
Tax Commission
(212) 669-3168
Taxi & Limousine Commission
(212) 840-4160
Teachers' Retirement System
(212) 566-7684

Traffic, Dept. of
(See Transportation, Dept. of)
Transit Authority
(718) 330-3373
Transportation, Dept. of
(212) 566-2269
Treasury, Dept. of
(See Finance, Dept. of)
Water Resources, Dept. of
(See Environmental Protection, Dept. of)
Youth Services, Dept. of
(718) 403-5246

THE CITY UNIVERSITY OF NEW YORK

Bernard M. Baruch College
(212) 387-1060
Borough of Manhattan Community College
(212) 618-1589
Bronx Community College
(212) 220-6034
Brooklyn College
(718) 780-5137
Central Office
City University of New York
(212) 794-5336
City College
(212) 690-4226
College of Staten Island
(718) 390-7842
LaGuardia Community College
(718) 482-5075
Graduate School & University Center
(212) 642-2622
Herbert H. Lehman College
(212) 960-8437
Hostos Community College
(212) 960-1096
Hunter College
(212) 772-4512, 4516, 4517
John Jay College
(212) 237-8520
Kingsborough Community College
(718) 368-5436
Medgar Evers College
(718) 270-4996
N.Y.C. Technical College
(718) 260-5650
Queens College
(718) 997-4460
Queensborough Community College
(718) 631-6269
York College
(718) 262-2135

HEALTH and HOSPITALS CORPORATION

Bellevue Hospital Center
(212) 561-4063
Bird S. Coler Memorial Hospital
(212) 848-6339, 6338
Bronx Municipal Hospital Center
(212) 918-3535
Brooklyn Central Laundry
(718) 735-3993
Coney Island Hospital
(718) 615-4748
Cumberland Family Care Center
(718) 260-7717, 7723
Elmhurst Hospital
(718) 565-4866
Emergency Medical Service
(718) 326-0600, Ext. 395
Goldwater Memorial Hospital
(212) 750-6691
Gouverneur Hospital
(212) 238-7639
Harlem Hospital Center
(212) 491-1831
Health and Hospitals Corporation
(212) 566-2990, 8006
Health and Hospitals Corporation, Helpline
(212) 391-4719
Kings County Hospital Center
(718) 245-2011
Lincoln Medical & Mental Health Center
(212) 579-5195
Metropolitan Hospital Center
(212) 230-7349
Morrisania Family Care Center
(212) 960-2744
Neponsit Health Care Center
(718) 474-1900, Ext. 318
North Central Bronx Hospital
(212) 519-3557
Nurse Referrals (HHC)
(212) 840-5228
Queens Hospital Center
(718) 883-2179
Sea View Hospital and Home
(718) 317-3290
Sydenham Family Care Center
(212) 932-6524
Woodhull Hospital
(718) 963-8852

CULTURAL INSTITUTIONS and LIBRARIES

American Museum of Natural History
(212) 769-5105
Brooklyn Botanical Garden & Arboretum
(718) 622-4433, Ext. 327
Bronx County Historical Society
(212) 881-8900
Bronx Museum of the Arts
(212) 681-6000
Brooklyn Academy of Music
(718) 636-4105
Brooklyn Children's Museum
(718) 735-4400
Brooklyn Museum
(718) 638-5000
Brooklyn Public Library
(718) 780-7764
El Museo del Barrio
(212) 831-7272
Fashion Institute of Technology
(212) 760-7699
Hall of Science of the City of New York
(718) 699-0005
Jamaica Arts Center
(718) 658-7400
Metropolitan Museum of Art
(212) 570-3761
Museum of the City of New York
(212) 534-1672
New York Botanical Garden
(212) 220-8744
New York Public Library
(212) 704-8669
New York Zoological Society
(212) 220-5087
Queens Borough Public Library
(718) 990-0787
Queens Botanical Garden
(718) 886-3800
Queens Museum
(718) 592-2405
Snug Harbor Cultural Center
(718) 448-2500
Staten Island Children's Museum
(718) 273-2060
Staten Island Historical Society
(718) 351-1617
Staten Island Inst. of Arts & Sciences
(718) 727-1135
Staten Island Zoological Society
(718) 442-3101
Wave Hill Center for Environmental
Studies (Perkins Garden)
(212) 549-3200

SECTION THREE

SUMMARY DESCRIPTION OF HEALTH PLANS

Summaries of the benefits of the available health plans appear on the pages that follow. They are presented so that it is easy to compare the benefits of the different plans.

This Summary Program Description is for informational purposes only. The benefits are subject to the terms, conditions and limitations of the applicable contracts and laws.

CIGNA HEALTHPLAN OF NEW YORK (formerly TOTAL HEALTH)

CIGNA HEALTHPLAN is a comprehensive health care plan designed for New York and New Jersey residents.

CIGNA HEALTHPLAN has approximately 4,000 physicians who are located throughout the five boroughs of New York City, Nassau and Suffolk Counties, and New Jersey. CIGNA HEALTHPLAN doctors see members in the privacy and comfort of their private offices.

As a CIGNA HEALTHPLAN member, you select your own doctor from a list of participating doctors. Each adult family member selects an internist or family doctor. Parents select a pediatrician or family doctor for children under 12 years. You may choose one doctor for the entire family or, if you prefer, a different doctor for each family member.

Once you have selected your doctor, you will receive a CIGNA HEALTHPLAN gold membership card showing your doctor's name and telephone number. This doctor will manage all your health care needs. If you require the care of a specialist, including an obstetrician/gynecologist, your doctor will make the necessary referrals and arrangements for you. The one exception is that a woman may see a participating obstetrician/gynecologist for her annual exam without a referral from her primary care physician. All visits to your doctor and to specialists recommended by your doctor are completely covered. If you are admitted to the hospital by your CIGNA HEALTHPLAN doctors, your hospital bill is paid by CIGNA HEALTHPLAN, including all approved surgery and anesthesia. There are no deductibles or copayments. You will never have to fill out a claim form or wait for reimbursement.

Should you require additional specialty care, physical or rehabilitation therapy, vision or hearing examinations, home care, durable medical equipment, allergy testing and treatments, laboratory testing, X-rays, maternity and well-baby care, you are completely covered.

Your CIGNA HEALTHPLAN coverage protects you 24 hours a day, seven days a week for emergencies. An emergency is defined as sudden and unexpected acute illness, acute pain or accidental injury which if not immediately diagnosed and treated could reasonably be expected to result in serious medical complications or loss of life. Emergencies are covered 100%, except for a \$35 copayment charged if you are not admitted to the hospital. Examples of serious medical emergencies include heart attack, stroke, loss of consciousness, loss of respiration, convulsions, poisoning and severe pain. Emergency care is covered anywhere in the world.

CIGNA HEALTHPLAN members can receive discounts for certain weight reduction and fitness programs.

Member Services representatives are available daily to answer your questions. They can be reached at (212) 617-1000, (718) 979-5555 or (516) 466-1000. For New Jersey residents, call (201) 361-8808 for further information, or (201) 361-1020 for Member Services if you are currently enrolled.

CIGNA HEALTHPLAN OF NEW YORK **SENIOR PARTNER PLAN**

This plan is not available to Medicare-eligible retirees living in New Jersey.

Medicare-eligible retirees residing in the New York Service Area who join CIGNA HEALTHPLAN are enrolled in the SENIOR PARTNER PLAN.

With CIGNA HEALTHPLAN SENIOR PARTNER PLAN, you receive unlimited private doctor visits and check-ups in the privacy of the doctor's office, unlimited hospitalization in prestigious teaching and neighborhood hospitals, wellness and preventive care programs, eye and hearing exams, and 24-hour emergency care 7 days a week, no matter where you are. There are no deductibles and no claim forms to file.

CIGNA HEALTHPLAN SENIOR PARTNER PLAN members also receive prescription benefits (with limited exclusions) at a cost of \$5 for generic medications and \$15 for brand name medications. Prescriptions must be written by CIGNA HEALTHPLAN SENIOR PARTNER PLAN participating physicians and filled at a participating pharmacy.

All medical care must be coordinated through your CIGNA HEALTHPLAN SENIOR PARTNER PLAN physician and the CIGNA HEALTHPLAN delivery system. Medical care not coordinated through CIGNA HEALTHPLAN SENIOR PARTNER PLAN primary care physicians or received outside the CIGNA HEALTHPLAN delivery system is not covered by CIGNA HEALTHPLAN SENIOR PARTNER PLAN or Medicare, except in an emergency or urgent situation. See pages 32 and 33 for additional information on the CIGNA HEALTHPLAN SENIOR PARTNER PLAN, an alternative Medicare program.

EXPANDED SERVICE AREA FOR RETIREES

Effective January 1, 1992, the CIGNA Medical Group Health Plan will be available to City of New York retirees living in the Los Angeles, Orange, and San Bernadino Counties of California. Plan benefits may differ. Copayments and deductibles may differ from those under CIGNA HEALTHPLAN of New York.

Member service numbers are: 1-800-344-0557
1-818-500-7000

OPTIONAL RIDER

An Optional Rider is available to all active employees and non-Medicare eligible retirees; for each prescription and refill you will pay only a \$3 copayment for a generic prescription and a \$6 copayment for a brand name prescription at participating NPA pharmacies.

COST

Please see page 45 for more information on payroll or pension deductions.

You may contact the health plan at:

1010 Northern Boulevard, Suite 324
Great Neck, NY 11021
(212) 617-1000
(718) 979-5555
(516) 466-1000

For New Jersey residents, call (201) 361-8808 for further information, or (201) 361-1020 for Member Services if you are currently enrolled.

CIGNA HEALTHPLAN

OUTPATIENT CARE

PHYSICIANS' OFFICE VISITS
SURGERY—PHYSICIAN'S OFFICE OR
HOSPITAL OUTPATIENT
LABORATORY AND X-RAY SERVICES

Coverage
*Covered in full
*Covered in full
*Covered in full

HOSPITAL CARE

SEMI-PRIVATE ROOM AND BOARD
PHYSICIANS' AND SURGEONS' SERVICES
GENERAL NURSING CARE
DRUGS AND MEDICATION
DIAGNOSTIC SERVICES (LAB WORK, X-RAYS)
INTENSIVE AND CORONARY CARE UNITS
USE OF OPERATING AND RECOVERY ROOM
ANESTHESIA

*Covered in full
*Covered in full
*Covered in full
*Covered in full
*Covered in full
*Covered in full
*Covered in full

EMERGENCY CARE

AMBULANCE SERVICE
DOCTORS' OFFICES
HOSPITAL EMERGENCY ROOM
URGENT CARE FACILITY

*Covered in full when medically necessary
*Covered in full
*\$35 copayment (waived if admitted to hospital)
*Covered in full

PREVENTIVE CARE

ROUTINE PHYSICAL CHECK-UP
ROUTINE PEDIATRIC (WELL-BABY) CARE
IMMUNIZATIONS
ROUTINE HEARING EXAMS / VISION CARE

*Covered in full
*Covered in full
*Covered in full (except for travel)
*Covered in full

MENTAL HEALTH AND CHEMICAL DEPENDENCY CARE

OUTPATIENT CHEMICAL DEPENDENCY

MENTAL HEALTH

INPATIENT CHEMICAL DEPENDENCY

MENTAL HEALTH

**Covered in full, 60-visit per 365-day period combined maximum for drug and/or alcohol treatment
*Covered for 20 visits per 365-day period, with variable copayments from \$0 to \$25
**Detoxification: Covered in full; 30-day per 365-day period combined annual maximum for drug and/or alcohol treatment (23 days of which will be charged to the mental health benefit)
Rehabilitation: Not Covered
*Covered in full; 30 days per 365-day period (23 days of which may be applied to the drug and/or alcohol coverage)

MATERNITY CARE

IN PHYSICIANS' OFFICES
PRENATAL AND POSTNATAL VISITS
IN THE HOSPITAL
PHYSICIANS' SERVICES—MOTHER AND NEWBORN
NEWBORN NURSERY SERVICES
MOTHER'S HOSPITAL SERVICES

*Covered in full
*Covered in full
*Covered in full
*Covered in full

HOME HEALTH CARE

HOME CARE SERVICES
HOSPICE CARE

*Covered in full when medically necessary
*Covered in full when medically necessary
*Covered in full when medically appropriate; 100-day limit

SKILLED NURSING FACILITY

REHABILITATION

PHYSICAL
SPEECH

*Covered in full—short-term rehabilitation
*Covered in full—short-term rehabilitation

PHARMACY SERVICES

FULL-TIME STUDENTS

See Optional Rider
Covered to age 23

*When provided or authorized by CIGNA HEALTHPLAN primary care physician.

**When provided or authorized by CIGNA HEALTHPLAN primary care physician, or referred by the Employee Assistance Program (EAP).

GHI-CBP/EMPIRE BLUE CROSS AND BLUE SHIELD

GHI COMPREHENSIVE BENEFITS PLAN

GHI's Comprehensive Benefits Plan (GHI-CBP) allows subscribers the freedom to choose any physician worldwide. GHI provides two forms of coverage combined in one plan. Subscribers receive paid-in-full benefits when they choose care from one of GHI's participating physicians and other health care providers. GHI maintains a network of over 15,000 participating physicians in the New York Metropolitan Area, and has many additional participating physicians and other health care providers throughout New York State and nationwide. All of these physicians and providers have agreed to accept GHI's allowances as payment in full. Payment for covered services is made directly to the participating provider. Home and office visits and out-of-hospital specialist consultations are subject to a \$10 copayment charge.

When you are unable to use the services of a participating provider, GHI also covers the services of non-participating providers. Payment for these services is made directly to you under the NYC Non-Participating Provider Schedule. Payment is subject to yearly deductibles (\$175 per person, maximum \$500 per family); a calendar year benefit maximum (\$100,000 per person); and a lifetime benefit maximum (\$1 million per person). Payment is made at 80% of the NYC Non-Participating Provider Schedule. After \$2,000 in coinsurance charges, GHI reimburses you at 100% of the NYC Non-Participating Provider Schedule. Coverage for professional private-duty nursing, equipment, appliances, oxygen and hospitalization coverage in excess of your Empire Blue Cross and Blue Shield coverage, is also available as a basic benefit.

A separate deductible of \$250 per person per calendar year is applied to private-duty professional nursing.

A copayment of \$10 is applied to out-of-hospital diagnostic X-ray and laboratory examinations.

A subscriber who chooses non-participating physicians for in-hospital care may incur catastrophic expenses. GHI Catastrophic Coverage pays additional amounts under such circumstances. Once a subscriber has incurred \$4,000 in covered expenses (based on physicians' usual and customary fees) GHI pays 100% of the reasonable and customary charges. The services to which Catastrophic Coverage applies (which are the same services that count toward the \$4,000 deductible) are: surgery, administration of anesthesia, maternity care, in-hospital medical care, radiation, chemotherapy, and expenses related to in-hospital X-ray and laboratory services.

GHI has a special Transfer Period phone number: (212) 799-6700.

You may contact the health plan at:

Group Health Incorporated
330 West 42nd Street
New York, NY 10036
(212) 721-7700

EMPIRE BLUE CROSS AND BLUE SHIELD HOSPITAL PLAN

The Empire Blue Cross and Blue Shield (EBCBS) Hospital Plan provides you with comprehensive hospitalization benefits. By presenting the Blue Cross Identification Card upon admission to any of over 6,000 Participating Hospitals nationwide, you avoid having to file claims.

As a registered bedpatient in any Blue Cross Participating Hospital, you are eligible to receive up to 21 days' hospitalization paid in full and the next 180 days paid at 50% of the hospital's charges.

Note: Effective August 1, 1991, each person is required to pay an inpatient deductible of \$200 per admission but not more than \$500 per person in a calendar year. Each family member must meet his or her deductible separately. Another admission within 90 days is counted as the same confinement and does not require a deductible to be paid. **The deductible does not apply to the following:** ill newborns who remain in the hospital after birth; Medicare eligibles; Home Care and Hospice benefits.

You receive benefits if you require hospitalization for illness or injury. Covered inpatient services include: semi-private room and board; general nursing care; drugs and medicines; the use of blood transfusion equipment; and the administration of blood or blood derivatives. Benefits are also provided for air ambulance services (not subject to the inpatient deductible) to hospitals in connection with an emergency situation, but only where no other transportation (such as commercial airlines or surface transportation) is available.

You receive outpatient benefits for a wide range of services and procedures. A total of 30 visits per person per calendar year are available for emergency care, minor surgery, and pre-surgical testing.

Note: Effective August 1, 1991, hospital charges for non-emergency outpatient treatment and ambulatory surgery are covered at 80% of approved charges. Each covered person pays 20% (coinsurance) not to exceed \$200 per calendar year. **This does not apply to the following:** emergency care or sudden and serious illness (subject to \$25 co-pay); pre-surgical testing; substance abuse counseling; air ambulance.

The EBCBS Hospital Plan offers special benefits for special health care needs. For example, inpatient benefits for mental and nervous disorders are available for up to 30 days per calendar year; up to 5 of these days can be used for alcohol detoxification, and up to 14 for drug detoxification, per admission. Outpatient benefits for rehabilitation for alcohol and drug abuse are provided for up to 60 visits per person per calendar year. Also, the Hospital Plan offers coverage for home care up to 200 visits per person per calendar year and hospice care for up to 210 days. Full benefits for all of these services are provided only when they are rendered in a participating facility.

Your EBCBS Hospital Plan is supported by a Dedicated Service Center, with personnel specially trained to understand your benefits. You may contact the plan at:

Empire Blue Cross and Blue Shield
City of New York Dedicated Service Center
P.O. Box 4883 Grand Central Station
New York, NY 10163
(212) 972-3700 or 1-800-422-9592

HOSPITAL PRE-ADMISSION AND MEDICAL CARE REQUIREMENTS

NYC HEALTHLINE: GHI-CBP/EBCBS and GHI Type C/EBCBS enrollees must call NYC HEALTHLINE (1-800-521-9574) prior to any scheduled hospital admission, any surgical procedure rendered in the outpatient department of a hospital, or having certain procedures performed in a doctor's office. Failure to call NYC HEALTHLINE may result in a penalty of up to \$500 from either your GHI or EBCBS coverage. See the NYC HEALTHLINE brochure ("3 Smart Reasons") or your plan booklets for details about this important program. For mental health/chemical dependency admissions, see footnote ("†") on page 9.

Outpatient Substance Abuse Treatment: To preserve your full health benefit for outpatient alcoholism treatment, you must call your Employee Assistance Program (EAP), the City's Central EAP (212) 306-7660 or your union counseling service for a referral letter; if you fail to do so, you will be subject to penalties. If you need help finding your EAP's phone number, call NYC HEALTHLINE or the Central EAP for assistance. ALL INFORMATION IS KEPT STRICTLY CONFIDENTIAL.

OPTIONAL RIDER

Additional GHI-CBP/EBCBS benefits for employees and retirees not eligible for Medicare are available under an Optional Rider. They include:

From GHI: Prescription drugs at 80% of reasonable and customary charges (subject to an annual \$150 deductible per person, \$450 per family); Maintenance drug plan (\$8 co-pay for a 60-day supply); \$500 maximum coinsurance, reduced from \$2,000 under the Basic plan (after the NYC Non-Participating Provider deductible has been met, plan pays 80% of scheduled allowance; once a member's coinsurance expenses reach \$500, the plan pays 100% of scheduled allowance); outpatient psychiatric care (50% of submitted charge, up to a maximum payment of \$30 per visit, \$700 annual maximum, \$2,500 lifetime maximum); average 50% increase in the NYC Non-Participating Provider Schedule for in-hospital and related procedures. Effective January 1992, extended medical coverage for unmarried full-time dependent students to age 23.

From EBCBS: 365 days of hospital protection; an additional 5 days inpatient detoxification and up to 30 days inpatient substance abuse rehabilitation per calendar year in an approved inpatient treatment facility (restrictions may apply to services rendered outside the Tri-State area); and extended hospital coverage for unmarried full-time dependent students to age 23.

GHI/EMPIRE BLUE CROSS AND BLUE SHIELD SENIOR CARE FOR MEDICARE-ELIGIBLE RETIREES

If you are a Medicare-eligible retiree enrolled in either GHI-CBP/EBCBS or GHI Type C/EBCBS, GHI/EBCBS Senior Care is available to supplement Medicare, as detailed on pages 10, 32 and 33.

COST All plan costs are noted on page 44.

GHI-CBP/EMPIRE BLUE CROSS AND BLUE SHIELD

	Coverage When Using a Participating Provider	Coverage When Using a Non-participating Provider
OUTPATIENT CARE PHYSICIANS' OFFICE VISITS SURGERY—PHYSICIAN'S OFFICE OR HOSPITAL OUTPATIENT	Covered by GHI with \$10 co-pay per visit	*80% after deductible, GHI benefit
HOSPITAL OUTPATIENT/AMBULATORY SURGERY	Covered in full by GHI (certain surgeries covered only when pre-certified by NYC HEALTHLINE)	*80% after deductible (certain surgeries covered only when pre-certified by NYC HEALTHLINE), GHI benefit
LABORATORY AND X-RAY ANESTHESIA SERVICES HOSPITAL CARE SEMI-PRIVATE ROOM AND BOARD	Covered by EBCBS at 80% of approved charges. Each covered person person pays 20% (coinsurance) not to exceed \$200 per calendar year \$10 co-pay Covered in full by GHI	Covered by EBCBS at 80% of approved charges. Each covered person person pays 20% (coinsurance) not to exceed \$200 per calendar year *80% after deductible, GHI benefit *80% after deductible, GHI benefit
PHYSICIANS' AND SURGEONS' SERVICES GENERAL NURSING CARE DRUGS AND MEDICATION DIAGNOSTIC SERVICES (LAB WORK, X-RAYS) INTENSIVE AND CORONARY CARE UNITS USE OF OPERATING AND RECOVERY ROOMS ANESTHESIA	Covered by EBCBS after \$200 deductible per admission/\$500 per person calendar year maximum; 21 Full Days, 180 days at 50% (additional coverage through the Optional Rider) subject to penalty if not precertified by NYC HEALTHLINE Covered in full by GHI Covered by EBCBS Covered by EBCBS Covered by EBCBS Covered by EBCBS Covered by EBCBS Covered in full by GHI	Covered by EBCBS after \$200 deductible per admission/\$500 per person calendar year maximum; 21 Full Days, 180 days at 50% (additional coverage through the Optional Rider) subject to penalty if not precertified by NYC HEALTHLINE *80% after deductible, GHI benefit Covered by EBCBS Covered by EBCBS Covered by EBCBS Covered by EBCBS Covered by EBCBS *80% after deductible, GHI benefit
EMERGENCY CARE AMBULANCE SERVICE	Covered up to \$100 by GHI; air ambulance coverage up to \$10,000 by EBCBS when medically necessary Covered by GHI with \$10 co-pay per visit Covered by EBCBS with \$25 co-pay (co-pay waived if admitted to hospital) Covered in full by GHI	Covered up to \$100 by GHI; air ambulance coverage up to \$10,000 by EBCBS when medically necessary *80% after deductible, GHI benefit Covered by EBCBS with \$25 co-pay (co-pay waived if admitted to hospital) *80% after deductible, GHI benefit
DOCTORS' OFFICES HOSPITAL EMERGENCY ROOM URGENT CARE FACILITY PREVENTIVE CARE ROUTINE PHYSICAL CHECK-UP ROUTINE PEDIATRIC (WELL-BABY) CARE IMMUNIZATIONS ROUTINE HEARING EXAMS/VISION CARE MENTAL HEALTH AND CHEMICAL DEPENDENCY CARE OUTPATIENT CHEMICAL DEPENDENCY	Not Covered Covered in full by GHI up to 5 office visits in first year of life Not Covered Not Covered Covered in full by EBCBS at a RECOVERReview SM treatment facility; 60-visit combined annual maximum for drug and/or alcohol treatment See Optional Rider	Not Covered \$12 payment by GHI, for each of 5 visits in first year of life Not Covered Not Covered Payment by EBCBS of 80% of allowable charges in an approved facility; 60-visit combined annual maximum for drug and/or alcohol treatment See Optional Rider
INPATIENT MENTAL HEALTH CHEMICAL DEPENDENCY	+Detoxification: Covered by EBCBS up to 30 days; 30- day combined annual maximum for drug, alcohol and/or mental health treatment (See Optional Rider for additional benefits) +Rehabilitation—See Optional Rider Physician: covered in full by GHI +Hospital: Covered by EBCBS up to 30 days in a non- governmental general hospital (GHI Basic Benefit \$10,000 annual/\$20,000 lifetime maximums up to 30 days combined GHI/EBCBS benefits); 30-day EBCBS combined annual maximum for drug, alcohol and/or mental health treatment	+Detoxification: Covered by EBCBS up to 30 days; 30- day combined annual maximum for drug, alcohol and/or mental health treatment (See Optional Rider for additional benefits) +Rehabilitation—See Optional Rider *Physician: 80% after deductible, GHI benefit +Hospital: Covered by EBCBS up to 30 days in a non- governmental general hospital (GHI Basic Benefit \$10,000 annual/\$20,000 lifetime maximums up to 30 days combined GHI/EBCBS benefits); 30-day EBCBS combined annual maximum for drug, alcohol and/or mental health treatment
MENTAL HEALTH		
MATERNITY CARE IN PHYSICIANS' OFFICES PRENATAL AND POSTNATAL VISITS IN THE HOSPITAL PHYSICIANS' SERVICES— MOTHER AND NEWBORN	Covered in full by GHI Mother: Covered in full by GHI Newborn: Covered in full by GHI if medically necessary Covered by EBCBS only if medically necessary Covered by EBCBS	*80% after deductible, GHI benefit *Mother: 80% after deductible, GHI benefit *Newborn: 80% after deductible if medically necessary, GHI benefit Covered by EBCBS only if medically necessary Covered by EBCBS
NEWBORN NURSERY SERVICES MOTHER'S HOSPITAL SERVICES HOME HEALTH CARE HOME CARE SERVICES HOSPICE CARE SKILLED NURSING FACILITY REHABILITATION PHYSICAL	Covered up to 200 visits per year by EBCBS Covered up to 210 days by EBCBS Not Covered	Covered up to 200 visits per year by EBCBS Covered up to 210 days by EBCBS Not Covered
SPEECH	\$10 co-pay per visit, 8-visit annual maximum, GHI benefit \$10 co-pay per visit, 16-visit annual maximum, GHI benefit See Optional Rider See Optional Rider	*80% after deductible, 8-visit annual maximum, GHI benefit *80% after deductible, 16-visit annual maximum, GHI benefit See Optional Rider See Optional Rider
PHARMACY SERVICES FULL-TIME STUDENTS		

NOTE:

GHI covers admissions for
diagnostic studies, rehabili-
tation, and excess days not
covered by Empire Blue
Cross and Blue Shield.

*When non-participating providers are used, GHI's Non-Participating Provider coverage applies; subject to a \$175 deductible per person per calendar year; (\$500 maximum family deductible); allowance based on 80% of the NYC Non-Participating Provider Schedule. After patient's coinsurance expense reaches \$2,000 (\$500 with Optional Rider), GHI pays 100% of scheduled allowance; \$100,000 annual benefit maximum, \$1 million lifetime benefit maximum.

+Substantial penalties may apply for services rendered outside the New York, New Jersey, Connecticut, and Pennsylvania area.

GHI TYPE C/EMPIRE BLUE CROSS AND BLUE SHIELD

GHI TYPE C

GHI Type C is a plan under which payment for physicians' bills is based on a schedule of allowances that has not been significantly improved since 1974. There is no deductible or coinsurance for many services. Benefits, although limited, are available world-wide.

	<u>GHI Pays</u>
Home Visit	\$10
Office Visit	\$ 7

Included in the benefit package are surgery and administration of anesthesia, maternity and well-baby care, in-hospital medical care, radiation therapy, specialist consultations, diagnostic procedures, allergy desensitization, X-ray examinations, lab tests, shock therapy, and intermittent nurse service in your home. Also covered are ambulance service, private duty professional nursing services, appliances, equipment and oxygen (all of which have 20% coinsurance and a combined annual \$25 deductible per contract and \$2,500 annual benefit maximum per person). GHI has a special Transfer Period phone number: (212) 799-6700.

You may contact the plan at: **Group Health Incorporated**
330 West 42nd Street, New York, NY 10036 (212) 721-2300

EMPIRE BLUE CROSS AND BLUE SHIELD HOSPITAL PLAN

The Empire Blue Cross and Blue Shield (EBCBS) Hospital Plan provides you with comprehensive hospitalization benefits. By presenting the Blue Cross Identification Card upon admission to any of 6,000 Participating Hospitals nationwide you avoid having to file claims or pay a deposit.

As a registered bedpatient in any Blue Cross Participating Hospital, you are eligible to receive up to 21 days hospital coverage paid in full and 180 days paid at 50% of the hospital's charges. Benefits are provided if you require hospitalization for illness, injury, or maternity care. Under a family contract, newborn

children are automatically covered from birth for treatment of illness or injury. Benefits will be provided for air ambulance services to hospitals in connection with an emergency situation, but only where no other transportation (such as commercial airlines or surface transportation) is available. Covered inpatient services include: semi-private room, board, general nursing care, drugs and medicines, the use of blood transfusion equipment, and the administration of blood or blood derivatives.

Outpatient benefits are provided for a wide range of services and procedures. A total of 30 visits per calendar year are available for emergency care, minor surgery, and pre-surgical testing. If the hospital is not a Participating hospital, an allowance of up to \$20 per visit will be paid.

Hospital coverage is not available for dependent children age 19 and over.

The EBCBS Hospital Plan offers special benefits for special health care needs. Benefits for mental or nervous disorders are available for up to 30 days per calendar year; up to 5 of these days can be used for alcohol detoxification, and up to 14 for drug detoxification, per admission. Outpatient benefits for rehabilitation of alcohol and drug abuse are provided for up to 60 visits per calendar year. In addition, the Hospital Plan offers coverage for Home Care up to 200 visits per calendar year and Hospice Care for up to 210 days. Full benefits for all these services are provided only when rendered by a Participating Facility.

Your EBCBS Hospital Plan is supported by a Dedicated Service Center, with personnel specially trained to understand your benefits. You may contact the plan at:

Empire Blue Cross and Blue Shield
City of New York Dedicated Service Center
P.O. Box 4883 Grand Central Station
New York, NY 10163
(212) 972-3700 or 1-800-422-9592

HOSPITAL PRE-ADMISSION AND MEDICAL CARE REQUIREMENTS

NYC HEALTHLINE: GHI Type C/EBCBS and GHI-CBP/EBCBS enrollees are subject to the requirements of NYC HEALTHLINE (1-800-521-9574). See page 8 for more information about this important program.

Outpatient Substance Abuse Treatment: To preserve your full health benefits for outpatient alcoholism treatment, you must call your Employee Assistance Program (EAP), the City's Central EAP (212) 306-7660 or your union counseling service for a referral letter; if you fail to do so, you will be subject to penalties. If you need help finding your EAP's phone number, call NYC HEALTHLINE or the Central EAP for assistance. ALL INFORMATION IS KEPT STRICTLY CONFIDENTIAL.

OPTIONAL RIDER

The program offers an Optional Rider with these additional benefits:

From GHI: Prescription drugs at 80% of reasonable and customary charges (subject to an annual \$150 deductible per person, \$450 per family); maintenance drug plan (\$8 for a 60-day supply).

From EBCBS: 365-day hospital protection.

NOTE: If your welfare fund provides benefits similar to those listed in the rider, those specific benefits will be provided through your welfare fund and the payroll or pension deduction will be reduced accordingly.

COST All plan costs are noted on page 44.

GHI/EMPIRE BLUE CROSS AND BLUE SHIELD SENIOR CARE FOR MEDICARE-ELIGIBLE RETIREES

If you are a Medicare-eligible retiree enrolled in either GHI-CBP/EBCBS or GHI Type C/EBCBS, GHI/EBCBS Senior Care supplements your Medicare coverage. Senior Care supplements Medicare for home and office visits, surgery and anesthesia, dental surgery, maternity care, in-hospital medical care, radiation therapy, specialist consultations, diagnostic procedures, X-ray examinations, laboratory tests, and shock therapy; also intermittent nurse service (Visiting Nurse Service) in your home. Medicare pays 80% of the Medicare-scheduled allowance, and Senior Care pays the remaining 20% for services both in and out of the hospital. If the Medicare deductible (currently \$100 per year) has been met through any of the services listed above, GHI will reimburse you that deductible.

EBCBS will supplement Medicare for inpatient hospital services, and will pay the Medicare inpatient deductible (currently \$628 per year).

Optional Rider: The program offers an Optional Rider with prescription drug coverage at 80% of reasonable and customary charges (subject to an annual deductible of \$150 per person and \$450 per family) and maintenance drug coverage (\$8 for a 60-day supply) through GHI, and hospital coverage up to 365 days through EBCBS.

If your welfare fund provides benefits similar to those listed in the Optional Rider, those specific benefits will only be provided through your welfare fund, and your pension deduction will be reduced accordingly.

See pages 32 and 33 for more information on GHI/EBCBS Senior Care. All plan costs are noted on page 44.

GHI TYPE C / EMPIRE BLUE CROSS AND BLUE SHIELD

OUTPATIENT CARE

PHYSICIANS' OFFICE VISITS
SURGERY—PHYSICIAN'S OFFICE OR
HOSPITAL OUTPATIENT
LABORATORY AND X-RAY SERVICES

Coverage

\$7 per visit, GHI benefit

Per GHI Schedule of Allowances
Per GHI Schedule of Allowances

Covered by EBCBS for 21 Full Days, 180 Days at 50%
(Additional coverage through Optional Rider)

Per GHI Schedule of Allowances

Payment by EBCBS

Payment by EBCBS

Payment by EBCBS

Payment by EBCBS

Payment by EBCBS

Per GHI Schedule of Allowances

Lesser of submitted charge or \$25, paid by GHI

\$7 per visit, paid by GHI

Covered by EBCBS within 12 hours of illness or 72 hours of
accident

\$7 per visit, paid by GHI

\$7 per visit, paid by GHI

\$7 per visit, paid by GHI

\$7 per visit, paid by GHI

Not Covered

Covered in full by EBCBS at a RECOVERreview^(SM) treatment
facility; 80% of allowable charges in an approved facility,
60-visit combined annual maximum for drug and/or
alcohol treatment

Not Covered

Detoxification: Covered by EBCBS; 30-day combined annual
maximum for drug, alcohol, and/or mental health
treatment

Rehabilitation: Not Covered

Physician or Psychologist: Per GHI Schedule of Allowances

Hospital: 30 days per year in a non-governmental general
hospital; 30-day combined annual maximum for drug,
alcohol and/or mental health treatment

Per GHI Schedule of Allowances

Per GHI Schedule of Allowances

Covered only if medically necessary, by EBCBS

Covered by EBCBS

Covered up to 200 visits per year by EBCBS

Covered up to 210 days by EBCBS

Not Covered

\$7 per visit, 4 visits per year, paid by GHI

\$7 per visit, 16 visits per year, paid by GHI

See Optional Rider

GHI medical benefits to age 23; EBCBS hospital benefits to
age 19

HOSPITAL CARE

SEMI-PRIVATE ROOM AND BOARD

PHYSICIANS' AND SURGEONS' SERVICES
GENERAL NURSING CARE
DRUGS AND MEDICATION
DIAGNOSTIC SERVICES (LAB WORK, X-RAYS)
INTENSIVE AND CORONARY CARE UNITS
USE OF OPERATING AND RECOVERY ROOM
ANESTHESIA

EMERGENCY CARE

AMBULANCE SERVICE
DOCTORS' OFFICES
HOSPITAL EMERGENCY ROOM

URGENT CARE FACILITY

PREVENTIVE CARE

ROUTINE PHYSICAL CHECK-UP
ROUTINE PEDIATRIC (WELL-BABY) CARE
IMMUNIZATIONS
ROUTINE HEARING EXAMS / VISION CARE

MENTAL HEALTH AND CHEMICAL DEPENDENCY CARE

OUTPATIENT CHEMICAL DEPENDENCY

INPATIENT MENTAL HEALTH
CHEMICAL DEPENDENCY

MENTAL HEALTH

MATERNITY CARE

IN PHYSICIANS' OFFICES
PRENATAL AND POSTNATAL VISITS
IN THE HOSPITAL
PHYSICIANS' SERVICES—MOTHER AND NEWBORN
NEWBORN NURSERY SERVICES
MOTHER'S HOSPITAL SERVICES

HOME HEALTH CARE

HOME CARE SERVICES
HOSPICE CARE

SKILLED NURSING FACILITY

REHABILITATION

PHYSICAL
SPEECH

PHARMACY SERVICES

FULL-TIME STUDENTS

EMPIRE BLUE CROSS AND BLUE SHIELD— HEALTHNET

HEALTHNET is a managed care program offered by Empire Blue Cross and Blue Shield. An Individual Practice Association (IPA) form of Health Maintenance Organization, HEALTHNET allows members to choose their primary care physicians from a Provider Directory of nearly 1,300 participating primary care physicians who can refer you to over 2,500 specialists located throughout the 27-county HEALTHNET service area of New York State. This service area includes New York City and the surrounding counties.

Comprehensive health care benefits, when provided or authorized by a HEALTHNET primary care physician, include full coverage for unlimited days of hospital care and referral to specialists, preventive care, maternity care, durable medical equipment, home health care, and skilled nursing care facility services.

IMPORTANT: In order to be covered under this program, all health care must be either provided or authorized by the member's primary care physician.

HEALTHNET requires no deductible, no coinsurance, few copayments, and virtually no claim forms. By using HEALTHNET's extensive network of doctors and other health care professionals, members avoid most inconveniences associated with the usual indemnity-type insurance coverage.

SELECTING A PRIMARY CARE PHYSICIAN

Each member of HEALTHNET, as well as each family member, chooses a primary care physician to provide and manage their health care. The primary care physician is responsible for referrals to specialists and for arranging hospitalization and any other needed medical and health care services. **PLEASE NOTE: IN ORDER TO RECEIVE HEALTHNET BENEFITS, YOU MUST SELECT A HEALTHNET PHYSICIAN FROM THE HEALTHNET DIRECTORY.** To obtain a directory, please call (212) 476-2358.

MEDICAL SERVICES

Medical services are rendered in either a physician's private office or at one of the multi-specialty groups, as well as their affiliated hospitals. There is a \$5 copayment required for each office visit to a primary care physician and referrals to specialists. Well-child care and pre-natal care are covered in full, without charge. All medically necessary services authorized by the primary care physician are covered.

HOSPITAL SERVICES

Customary hospitalization charges, as well as newborn nursery charges, are covered in full. Emergency room services require a \$35 copayment, unless followed by hospitalization for the same condition within three days.

PREVENTIVE SERVICES

HEALTHNET covers a wide range of preventive and healthy lifestyle services. These services include routine physical examinations for all members of the family, pre- and post-natal care, well-child care, Pap tests, comprehensive vision and hearing examinations, family planning, and health and nutrition counseling.

COVERAGE WHILE TRAVELLING

Emergency room care when travelling in or outside the HEALTHNET service area is covered when the onset of the medical condition is unexpected and of such a nature that failure to obtain immediate care would result in a deterioration of the patient's condition, which would cause serious impairment or threat to life. Again, emergency room services require a \$35 copayment unless followed by hospitalization for the same condition within three days. Your HEALTHNET primary care physician must be notified within three days if you are hospitalized. Your HEALTHNET card will be accepted automatically at any one of over 6,000 Blue Cross Participating Hospitals in the US and Canada.

Urgent care is non-emergency care which still requires immediate attention and cannot wait until your return to your primary care physician and the HEALTHNET service area. When out-of-area urgent care is needed, members should call their primary care physician for medical direction. Whatever is authorized will be covered in full (excluding prescriptions). You may also call HEALTHNET's toll-free emergency hotline 24 hours a day, 7 days a week at 1-800-453-0113 for information on the availability of medical care in the area in which you are travelling.

HEALTHNET MEDICARE

If you are retired with both Medicare Parts A and B you are also eligible for HEALTHNET. This plan provides the same comprehensive benefits as the standard HEALTHNET program, and also includes coverage for the deductibles, coinsurance, and services not covered by Medicare Parts A and B, but not to exceed coverage available through HEALTHNET'S standard program.

TO BE COVERED IN FULL, MEDICARE-ELIGIBLES MUST USE HEALTHNET PHYSICIANS. If a non-HEALTHNET physician is used, only Medicare coverage is applicable, and benefits are subject to deductibles, copayments, and exclusions. See pages 32 and 33 for additional information on the HEALTHNET Medicare program.

OPTIONAL RIDER

An Optional Rider for prescription drugs (\$5 co-pay per prescription or refill) is also available to subscribers through EBCBS HEALTHNET.

COST

Please see page 44 for information on payroll or pension deductions.

FOR ADDITIONAL INFORMATION

If you have questions about any aspect of the HEALTHNET program, please call the HEALTHNET Information Center toll-free at 1-800-342-9741, 8:30 am to 5:00 pm, Monday through Friday.

During the City of New York Transfer Period, specially-trained Customer Service Representatives will be available to provide specific information and assistance to you at (212) 476-2358, 8:30 am to 5:00 pm, Monday through Friday.

**EMPIRE BLUE CROSS AND BLUE SHIELD—
HEALTHNET**

OUTPATIENT CARE		Coverage
PHYSICIANS' OFFICE VISITS		*\$5 copayment
SURGERY—PHYSICIAN'S OFFICE OR HOSPITAL OUTPATIENT		*Covered in full
LABORATORY AND X-RAY SERVICES		*Covered in full
HOSPITAL CARE		
SEMI-PRIVATE ROOM AND BOARD		*Covered in full
PHYSICIANS' AND SURGEONS' SERVICES		*Covered in full
GENERAL NURSING CARE		*Covered in full
DRUGS AND MEDICATION		*Covered in full
DIAGNOSTIC SERVICES (LAB WORK, X-RAYS)		*Covered in full
INTENSIVE AND CORONARY CARE UNITS		*Covered in full
USE OF OPERATING AND RECOVERY ROOMS		*Covered in full
ANESTHESIA		*Covered in full
EMERGENCY CARE		
AMBULANCE SERVICE		*Covered in full
DOCTORS' OFFICES		*\$5 copayment
HOSPITAL EMERGENCY ROOM		*\$35 copayment (waived if hospitalized within 72 hours)
PREVENTIVE CARE		
ROUTINE PHYSICAL CHECK-UP		*Covered in full
ROUTINE PEDIATRIC (WELL-BABY) CARE		*Covered in full
IMMUNIZATIONS		*Covered in full
ROUTINE HEARING EXAMS / VISION CARE		*Covered in full
MENTAL HEALTH AND CHEMICAL DEPENDENCY CARE		
OUTPATIENT CHEMICAL DEPENDENCY		**Covered in full at an approved treatment facility, 60-visit combined annual maximum for drug and/or alcohol treatment
		*\$25 copayment, up to 20 visits per calendar year
		**Detoxification: 30-day maximum per year
		*Rehabilitation: Covered in full up to 30 days, 90 days day/night care (non-medical) facility; 120-day combined annual maximum for drug and/or alcohol treatment
		*Covered in full up to 30 days
	MENTAL HEALTH	
INPATIENT	CHEMICAL DEPENDENCY	
	MENTAL HEALTH	
MATERNITY CARE		
IN PHYSICIANS' OFFICES		
PRENATAL AND POSTNATAL VISITS		*Covered in full
IN THE HOSPITAL		
PHYSICIANS' SERVICES—MOTHER AND NEWBORN		*Covered in full
NEWBORN NURSERY SERVICES		*Covered in full
MOTHER'S HOSPITAL SERVICES		*Covered in full
HOME HEALTH CARE		
HOME CARE SERVICES		*Covered in full
HOSPICE CARE		*Covered in full
SKILLED NURSING FACILITY		
REHABILITATION		
PHYSICAL		*Covered in full short term (20 visits)
SPEECH		*Covered in full
PHARMACY SERVICES		See Optional Rider
FULL-TIME STUDENTS		Covered to age 25

*All services must be provided or authorized by your HEALTHNET Primary Care Physician.

**When provided or authorized by a HEALTHNET physician or referred by the Employee Assistance Program (EAP).

HIP/HMO

The Health Insurance Plan of Greater New York (HIP) was the first health plan of its kind in New York and is the largest Health Maintenance Organization (HMO) outside California. HIP/HMO provides comprehensive hospitalization and medical benefits to over 900,000 New Yorkers, including 300,000 City employees, retirees and their family members.

Medical care is provided by the more than 1,000 selected doctors of HIP at over 50 multi-specialty and primary care centers located in the five boroughs of New York City, Nassau, Suffolk and Westchester Counties, and New Jersey. City retirees who are under age 65 and live in our service area for Florida or New Jersey may enroll in HIP/HMO.

Members of HIP/HMO, by using HIP/HMO services, have no doctor bills, no hospital bills and no claim forms. There are no limitations on medical visits and hospitalization is covered in full.

Upon joining, members select a medical group, a medical center and a personal family physician for adults and a pediatrician for dependent children. These physicians have the responsibility for primary care and for referrals to other specialists affiliated with the medical group. A full range of one-stop medical services is then available, generally at the member's center, occasionally through referral elsewhere.

Visits to the medical center are by appointment. If an urgent medical need arises, members can call the center for a same-day appointment. If an emergency arises when the centers are closed (evenings, weekends or holidays), the Emergency Services Program (ESP) should be called toll-free at 1-800-HIP-HELP. Through ESP, HIP provides around-the-clock access to urgent and emergency medical care; both physicians and nurses are available to give advice or referrals to an HIP after-hours Treatment Center, or hospital emergency room. Emergency hospitalization and medical care are covered when a member is travelling, or so severely injured that authorization by HIP is not feasible.

OPTIONAL RIDER

HIP/HMO offers an Optional Rider which provides full coverage for prescription drugs at over 1,000 participating pharmacies. The rider also covers appliances provided through designated suppliers, and private-duty nursing (in-hospital only) when prescribed by an HIP physician. If your welfare fund provides benefits similar to those listed in the rider, those specific benefits will be provided through your welfare fund, and your payroll or pension deductions will be reduced accordingly.

HIP "FITNESS FORMULA" BENEFITS

As part of HIP's ongoing commitment to keeping members healthy, several programs are offered, including Smoking Cessation Program, Weight Management Program, Stress Management and Fitness Incentives. Please refer to your HIP booklet for more information on these programs.

HIP VIP MEDICARE PROGRAM

The HIP VIP Medicare Program provides comprehensive medical and hospital benefits to City of New York retirees and their spouses who are enrolled in Medicare Parts A and B. Medicare-eligible retirees **must** be enrolled in Medicare Part B. However, Medicare-eligible retirees who are not eligible for Part A may remain in HIP. There are no pension deductions or additional charges for the HIP VIP Plan, which includes these additional benefits:

Coverage for prescription drugs prescribed by your HIP physician and obtained through any one of more than 1,000 participating pharmacies (There is a \$2.50 copayment per 30-day supply of each covered prescription); prescription eyeglasses every 24 months (from a special selection); in-hospital private-duty nursing when ordered by an HIP physician; up to 4 routine foot-care visits per year; up to \$300 toward the purchase of a hearing aid

every three years; full coverage for short term treatment of mental or nervous disorders; and certain prosthetic devices and appliances.

In exchange for the comprehensive medical and full hospital coverage plus all the special benefits available through HIP VIP, the member agrees to obtain all his or her medical and hospital services through HIP. Any medical care, except for covered emergencies or urgently needed care out of the area, that is neither provided nor authorized by HIP, will not be covered by either HIP or Medicare.

FLORIDA/NEW JERSEY RESIDENTS: Retirees who are 65 years of age or older, are Medicare-eligible and have Parts A & B of Medicare may also enroll in HIP's Medicare Cost Program. Under the HIP Medicare Cost Program enrollees may continue to use the services of HIP and will retain the use of their Medicare card outside HIP. See the next section for more information.

HIP MEDICARE COST PROGRAM

HIP/MCP provides comprehensive medical and hospital benefits to New York City retirees and their spouses enrolled in Parts A and B of Medicare who were members of HIP/MCP prior to July 1, 1987.

The benefits available to the Medicare Cost members are the same as those described for HIP/HMO, with the following additional benefits at no cost:

In-hospital private-duty nursing when ordered by an HIP physician, psychiatric services for mental or nervous disorders, and certain prosthetic devices and appliances.

Elective medical services (non-emergency) provided by non-HIP physicians are covered only by Medicare and are subject to Medicare deductibles, coinsurance payments and exclusions. HIP does not supplement Medicare coverage for such services. HIP Medicare Cost members may also choose full coverage of prescription drugs through an Optional Rider. The election of this benefit results in monthly pension deductions. For more information on the HIP Medicare Cost Program, see pages 32 and 33.

FLORIDA/NEW JERSEY RESIDENTS: Retirees who are 65 years of age or older, are Medicare-eligible and have Parts A & B of Medicare may also enroll in HIP's Medicare Cost Program. Under the HIP Medicare Cost Program enrollees may continue to use the services of HIP and will retain the use of their Medicare card outside HIP.

INTERPLAN

HIP is able to serve its members who travel in South Florida, through its affiliate, HIP Network of Florida. Services are provided in Dade, Broward and Palm Beach counties. Members vacationing in the Florida service area may arrange reciprocity through HIP Interplan, either in advance or upon determining that care is needed.

Those employees and retirees who are planning a vacation in the Florida service area may arrange for medical treatment by calling HIP Interplan at 1-800-223-0654. They will be referred to an HIP physician whose office is near the location where they will be staying.

COST All plan costs are noted on page 44.

You may contact the health plan at:

220 West 58th Street, New York, NY 10019 • 1-800-HIP-TALK

During the New York City Transfer Period, specially trained representatives will be available Monday to Thursday, 5:00 PM to 7:30 PM.

HIP/HMO

OUTPATIENT CARE

PHYSICIANS' OFFICE VISITS
SURGERY—PHYSICIAN'S OFFICE OR
HOSPITAL OUTPATIENT
LABORATORY AND X-RAY SERVICES

HOSPITAL CARE

SEMI-PRIVATE ROOM AND BOARD
PHYSICIANS' AND SURGEONS' SERVICES
GENERAL NURSING CARE
DRUGS AND MEDICATION
DIAGNOSTIC SERVICES (LAB WORK, X-RAYS)
INTENSIVE AND CORONARY CARE UNITS
USE OF OPERATING AND RECOVERY ROOM
ANESTHESIA
PRIVATE-DUTY NURSING

EMERGENCY CARE

AMBULANCE SERVICE

DOCTORS' OFFICES

HOSPITAL EMERGENCY ROOM
URGENT CARE FACILITY

PREVENTIVE CARE

ROUTINE PHYSICAL CHECK-UP
ROUTINE PEDIATRIC (WELL-BABY) CARE
IMMUNIZATIONS
ROUTINE HEARING EXAMS / VISION CARE
ROUTINE FOOTCARE

MENTAL HEALTH AND CHEMICAL DEPENDENCY CARE

OUTPATIENT CHEMICAL DEPENDENCY

INPATIENT MENTAL HEALTH
 CHEMICAL DEPENDENCY

MENTAL HEALTH

MATERNITY CARE

IN PHYSICIANS' OFFICES
PRENATAL AND POSTNATAL VISITS
IN THE HOSPITAL
PHYSICIANS' SERVICES—MOTHER AND NEWBORN
NEWBORN NURSERY SERVICES
MOTHER'S HOSPITAL SERVICES

HOME HEALTH CARE

HOME CARE SERVICES
HOSPICE CARE

SKILLED NURSING FACILITY

REHABILITATION

PHYSICAL
SPEECH

PHARMACY SERVICES

FULL-TIME STUDENTS

Coverage

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

Covered in full when authorized by HIP, otherwise
100% of the usual and customary charge

Covered in full when authorized by HIP, otherwise
100% of the usual and customary charge

Covered in full

Covered in full when authorized by HIP, otherwise
100% of the usual and customary charge

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered for 4 visits per calendar year

***Covered in full, 60-visit combined annual maximum for
drug and/or alcohol treatment

*One psychiatric assessment visit per year at HIP

*Detoxification: Covered in full, 30-day combined annual
maximum for drug, alcohol, and/or mental health
treatment

Rehabilitation: Not Covered

*Covered in full up to 30 days per year in a psychiatric
section of a general hospital; 30-day combined annual
maximum for drug, alcohol, and/or mental health
treatment

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in lieu of inpatient stay

*Covered up to 210 days

**Covered in full when criteria are met

*Covered in full for first 30 days of each admission

*Covered in full for first 30 days of each admission

Available through Optional Rider

Covered to age 23

*When provided or authorized by an HIP physician

**Authorized when care (1) follows a hospital stay, and (2) is in lieu of hospitalization.

***When provided or authorized by an HIP physician or referred by the Employee Assistance Program (EAP).

HIP CHOICE

HIP CHOICE allows the flexibility of receiving care from the physicians of HIP while maintaining the option to use any other physician whenever desired. Under this plan, all HIP/HMO benefits are available when provided or arranged by HIP doctors, including full coverage for check-ups, well-baby care, routine immunizations, and eye exams. There are no deductibles, copayments, or penalties for services provided by HIP. Hospitalization by an HIP doctor is also fully covered.

In addition, the HIP CHOICE subscriber can use any other doctors at any time and be reimbursed for up to 60% of the doctor's fee. Coverage is subject to a deductible. Full coverage for inpatient hospital care, skilled nursing facility care and home care arranged by non-HIP physicians is available if prior approval is obtained from HIP.

For care from non-HIP doctors, HIP CHOICE members are subject to a \$200 annual deductible per individual, with a \$400 annual family maximum. Thereafter, members will be reimbursed for 60% of what HIP CHOICE determines as reasonable and customary charges for the services provided. Coinsurance is the responsibility of the subscriber but only until a \$1,000 annual maximum per individual or \$2,000 per family is reached. HIP CHOICE will then pay 100% of further reasonable and customary charges. The member will still be responsible for any charges above what HIP considers reasonable and customary. Periodic health exams, well-baby care, routine immunizations, and eye exams are not covered when provided by a non-HIP doctor.

OPTIONAL RIDER

HIP CHOICE offers an Optional Rider. The rider fully covers, at over 1,000 participating pharmacies, drugs prescribed by an HIP physician. Prescription drugs not prescribed by an HIP physician are subject to a \$3 copayment per 30-day supply at participating pharmacies.

HIP "STAY HEALTHY" BENEFITS

As part of HIP's ongoing commitment to keeping members healthy, several programs are offered, including Smoking Cessation Program, Weight Management Program, Stress Management, and Fitness Incentives. Please refer to your HIP booklet for more information on these programs.

HIP VIP MEDICARE PROGRAM

The HIP VIP Medicare Program provides comprehensive medical and hospital benefits to City of New York retirees and their spouses who are enrolled in Parts A and B of Medicare. Medicare-eligible retirees **must** be enrolled in Medicare Part B. However, Medicare-eligible retirees who are not eligible for Part A may remain in HIP. There are no pension deductions or additional charges for the HIP VIP Plan, which includes these additional benefits:

Coverage for prescription drugs prescribed by your HIP physician and obtained through any one of more than 1,000 participating pharmacies; (There is a \$2.50 copayment per 30-day supply of each covered prescription); prescription eyeglasses every 24 months (from a special selection); in-hospital private duty nursing when ordered by an HIP physician; up to 4 routine footcare visits per year; up to \$300 toward the purchase of a hearing aid every three years; full coverage for short term treatment of mental or nervous disorders, and certain prosthetic devices and appliances.

In exchange for the comprehensive medical and full hospital coverage plus all the special benefits available through HIP VIP, the member agrees to obtain all his or her medical and hospital services through HIP. Any medical care, except for covered emergencies or urgently needed care out of the area, that is neither provided nor authorized by HIP, will not be covered by either HIP or Medicare.

FLORIDA/NEW JERSEY RESIDENTS: Retirees who are 65 years of age or older, are Medicare-eligible and have Parts A & B of Medicare may also enroll in HIP's Medicare Cost Program. Under the HIP Medicare Cost Program enrollees may continue to use the services of HIP and will retain the use of their Medicare card outside HIP. See the next section for more information.

HIP MEDICARE COST PROGRAM

HIP/MCP will continue to provide comprehensive medical and hospital benefits to New York City retirees and their spouses enrolled in Parts A and B of Medicare who were members of HIP/MCP prior to July 1, 1987.

The benefits available to the Medicare Cost members are the same as those described for HIP/HMO, with the following additional benefits at no cost:

In-hospital private duty nursing when ordered by an HIP physician, psychiatric services for mental or nervous disorders, and certain prosthetic devices and appliances.

Elective medical services (non-emergency) provided by non-HIP physicians are covered only by Medicare and are subject to Medicare deductibles, coinsurance payments, and exclusions. HIP does not supplement coverage for such services. HIP Medicare Cost members may also choose full coverage of prescription drugs through an Optional Rider. The election of this benefit results in monthly pension deductions. For more information on the HIP Medicare Cost Program, see pages 32 and 33.

FLORIDA/NEW JERSEY RESIDENTS: Retirees who are 65 years of age or older, are Medicare-eligible and have Parts A & B of Medicare may also enroll in HIP's Medicare Cost Program. Under the HIP Medicare Cost Program enrollees may continue to use the services of HIP and will retain the use of their Medicare card outside HIP.

INTERPLAN

HIP is able to serve its members who travel in South Florida, through its affiliate, HIP Network of Florida. Services are provided in Dade, Broward and Palm Beach counties. Members vacationing in the Florida service area may arrange reciprocity through HIP Interplan, either in advance or upon determining that care is needed.

Those employees and retirees who are planning a vacation in the Florida service area may arrange for medical treatment by calling HIP Interplan at 1-800-223-0654. They will be referred to an HIP physician whose office is near the location where they will be staying. Employees who are retiring and moving to the HIP Network service area may arrange to receive services from the HIP Network by contacting the HIP Member Services Department (1-800-HIP-TALK).

HIP CHOICE coverage is not available to permanent residents of Florida. HIP CHOICE members who are visiting Florida may arrange to receive treatment from HIP-affiliated physicians through HIP Interplan, or may receive treatment from any physician, subject to the deductible and copayment.

COST All plan costs are noted on page 44.

You may contact the health plan at:

**220 West 58th Street
New York, NY 10019
1-800-HIP-TALK**

During the New York City Transfer Period, specially trained representatives will be available Monday to Thursday, 5:00 PM to 7:30 PM.

HIP CHOICE

OUTPATIENT CARE		COVERAGE FOR SERVICES FROM HIP	COVERAGE FOR SERVICES NOT FROM HIP
PHYSICIANS' OFFICE VISITS		Covered in full	*60%
SURGERY—PHYSICIAN'S OFFICE OR HOSPITAL OUTPATIENT		Covered in full	*60%
LABORATORY AND X-RAY SERVICES		Covered in full	*60%
HOSPITAL CARE			
SEMI-PRIVATE ROOM AND BOARD		Covered in full	**Covered in full
PHYSICIANS' AND SURGEONS' SERVICES		Covered in full	*60%
GENERAL NURSING CARE		Covered in full	**Covered in full
DRUGS AND MEDICATION		Covered in full	**Covered in full
DIAGNOSTIC SERVICES (LABWORK, X-RAYS)		Covered in full	**Covered in full
INTENSIVE AND CORONARY CARE UNITS		Covered in full	**Covered in full
USE OF OPERATING AND RECOVERY ROOMS		Covered in full	**Covered in full
ANESTHESIA		Covered in full	*60%
PRIVATE DUTY NURSING		Covered in full	**Covered in full
EMERGENCY CARE			
AMBULANCE SERVICE		Covered in full in connection with hospital admission or covered Emergency Room services	Covered in full in connection with hospital admission or covered Emergency Room services
DOCTORS' OFFICES		Covered in full	*60%
HOSPITAL EMERGENCY ROOM		Covered in full within 12 hours of illness or 72 hours of accident	Covered in full within 12 hours of illness or 72 hours of accident
URGENT CARE FACILITY		Covered in full	*60% of physician services
PREVENTIVE CARE			
ROUTINE PHYSICAL CHECK-UP		Covered in full	Not covered
ROUTINE PEDIATRIC (WELL-BABY) CARE		Covered in full	Not covered
IMMUNIZATIONS		Covered in full	Not covered
ROUTINE HEARING EXAMS / VISION CARE		Covered in full	Not covered
ROUTINE FOOTCARE		Covered for 4 visits per calendar year	Not covered
MENTAL HEALTH AND CHEMICAL DEPENDENCY CARE			
OUTPATIENT	CHEMICAL DEPENDENCY	**Covered in full, 60-visit combined annual maximum for drug and/or alcoholism treatment	***60%
		One psychiatric assessment visit per year at HIP	
INPATIENT	MENTAL HEALTH	**Detoxification: Covered in full	Not covered
	CHEMICAL DEPENDENCY	Rehabilitation: Not covered	**Detoxification: Covered in full
	MENTAL HEALTH	**Covered in full	Rehabilitation: Not covered
MATERNITY CARE			
IN PHYSICIANS' OFFICES			
PRENATAL AND POSTNATAL VISITS		Covered in full	*60%
IN THE HOSPITAL			
PHYSICIANS' SERVICES—			
MOTHER AND NEWBORN		Covered in full	*60% (Well-baby care not covered)
NEWBORN NURSERY SERVICES		Covered in full	Covered in full
MOTHER'S HOSPITAL SERVICES		Covered in full	Covered in full
HOME HEALTH CARE			
HOME CARE SERVICES		Covered in full	
HOSPICE CARE		210 days covered in full	40 visits covered in full, additional visits 50% covered
			210 days covered in full
SKILLED NURSING FACILITY			
		Covered in full following hospital stay, in lieu of hospitalization	Covered in full with approval; 50% without approval
REHABILITATION			
PHYSICAL		Covered in full, limited to first 30 days of each admission	*60%—limited to first 30 days of each admission
SPEECH		Covered in full, limited to first 30 days of each admission	*60%—limited to first 30 days of each admission
APPLIANCES			
		Covered in full	Covered in full with approval; 50% without approval
PHARMACY SERVICES			
FULL-TIME STUDENTS		See Optional Rider	See Optional Rider
		Covered to age 23	Covered to age 23

- *The subscriber must satisfy a deductible (\$200 per individual, \$400 per family) after which reimbursement will be 60% of the usual, customary, and reasonable charge. Subscriber must pay excess above usual, customary, and reasonable charge. When 40% coinsurance reaches \$1,000 per individual or \$2,000 per family in a calendar year, HIP CHOICE will pay 100% of the usual and customary charges for the remainder of the calendar year.
- **With prior approval of HIP, all Hospital, Skilled Nursing Facility, and Home Care services are covered in full, except that inpatient drug and/or alcohol detoxification and mental health services are limited to a total of 30 days per calendar year. Subscriber is responsible for 50% of charges when prior approval is not obtained.
- ***Without prior approval or approval within first 10 days—coverage limited to 10 days. After deductible, HIP will pay 60% of reasonable and customary charges.

MED PLAN

Med Plan is offered to Health and Hospitals Corporation (HHC) employees and non-Medicare eligible retirees and their dependents; current Med Plan members who are not HHC employees may stay in the plan.

Med Plan is a pre-paid group medical practice. Comprehensive health care is provided at the Med Plan Center, 26th Street and First Avenue in Manhattan.

The emphasis at Med Plan is on convenient, comprehensive, quality medical care. Med Plan physicians (primary care as well as specialists) are board-certified in their medical fields and all are members of the teaching faculty of New York University School of Medicine.

Med Plan members select a personal physician from among the Med Plan primary care physicians. This physician provides primary care (check-ups, routine visits) and coordinates all health care needs through referrals to specialists as needed. Inpatient care is provided at Bellevue Hospital Center.

As a member of Med Plan you will be covered in full for a wide range of health care services including office visits, hospital visits and surgical care, emergency visits, maternity and pediatric care and psychiatric care. Some special features of Med Plan include preventive health, health education, and second surgical consultation services. There are no deductibles, no bills, no forms and no cost for covered services when authorized by Med Plan.

The Med Plan Center has convenient evening and weekend hours for scheduled appointments and urgent walk-ins: Monday, Tuesday and Friday 8:30 am-5:00 pm; Wednesday and Thursday,

8:30 am-7:00 pm; and the first Saturday of each month (on an appointment basis only).

Med Plan has an Emergency Hotline (212) 685-3005 which is open 24 hours/7 days a week. Members can call the Hotline any time they need help or advice for a medical problem. This service reduces the need for an emergency room visit.

OPTIONAL RIDER

Med Plan offers an Optional Rider which provides prescription drugs at no charge when prescribed by a Med Plan physician and dispensed through either Bellevue Hospital Center or one of the designated pharmacies in the Med Plan vicinity. When ordered by Med Plan, private-duty nursing in the hospital and covered appliances and prosthetics are covered. If your welfare fund provides benefits similar to those listed in the rider, those specific benefits will be provided through your welfare fund and your payroll deductions will be reduced accordingly.

MED PLAN MEDICARE

Med Plan is not offered to Medicare-eligible retirees.

COST

All plan costs are noted on page 45.

You may contact the plan at:

**450 First Avenue
New York, NY 10016
(212) 685-3005**

MED PLAN

OUTPATIENT CARE		Coverage
PHYSICIANS' OFFICE VISITS		*Covered in full
SURGERY—PHYSICIAN'S OFFICE OR HOSPITAL OUTPATIENT		
LABORATORY AND X-RAY SERVICES		*Covered in full
HOSPITAL CARE		*Covered in full
SEMI-PRIVATE ROOM AND BOARD		*Covered in full
PHYSICIANS' AND SURGEONS' SERVICES		*Covered in full
GENERAL NURSING CARE		*Covered in full
DRUGS AND MEDICATION		*Covered in full
DIAGNOSTIC SERVICES (LAB WORK, X-RAYS)		*Covered in full
INTENSIVE AND CORONARY CARE UNITS		*Covered in full
USE OF OPERATING AND RECOVERY ROOM		*Covered in full
ANESTHESIA		*Covered in full
EMERGENCY CARE		
AMBULANCE SERVICE		*Covered in full
DOCTORS' OFFICES		*Covered in full
HOSPITAL EMERGENCY ROOM		*Covered in full
URGENT CARE FACILITY		*Covered in full
PREVENTIVE CARE		
ROUTINE PHYSICAL CHECK-UP		*Covered in full
ROUTINE PEDIATRIC (WELL-BABY) CARE		*Covered in full
IMMUNIZATIONS		*Covered in full
ROUTINE HEARING EXAMS / VISION CARE		*Covered in full
MENTAL HEALTH AND CHEMICAL DEPENDENCY CARE		
OUTPATIENT CHEMICAL DEPENDENCY		**Covered in full, 60-visit combined annual maximum for drug and/or alcohol treatment
	MENTAL HEALTH	*Covered for 1 visit per calendar year for diagnostic purposes
INPATIENT CHEMICAL DEPENDENCY		**Detoxification: Covered in full; 30-day combined annual maximum for drug, alcohol, and/or mental health treatment
	MENTAL HEALTH	Rehabilitation: Not Covered
		*Covered in full 30 days in a psychiatric section of a general hospital (professional component not covered); 30-day combined annual maximum for drug, alcohol, and/or mental health treatment
MATERNITY CARE		
IN PHYSICIANS' OFFICES		
PRENATAL AND POSTNATAL VISITS		*Covered in full
IN THE HOSPITAL		
PHYSICIANS' SERVICES—MOTHER AND NEWBORN		*Covered in full
NEWBORN NURSERY SERVICES		*Covered in full
MOTHER'S HOSPITAL SERVICES		*Covered in full
HOME HEALTH CARE		
HOME CARE SERVICES		
HOSPICE CARE		*Intermittant Nursing Service—Covered in full Not Covered
SKILLED NURSING FACILITY		*Covered in lieu of hospitalization when medically necessary
REHABILITATION		
PHYSICAL		*Covered in full, short term Not Covered
SPEECH		See Optional Rider
PHARMACY SERVICES		Covered to age 23
FULL-TIME STUDENTS		

*When provided or authorized by a Med Plan doctor.

**When provided or authorized by a Med Plan doctor, or referred by the Employee Assistance Program (EAP).

DC 37 MED-TEAM

Available only to DC 37 members, retirees, and their families, DC 37 Med-Team is an innovative health care program that offers a full range of coverage, all provided within local communities where members live or work. Med-Team emphasizes preventive care and encourages members to see their primary care physicians when they are healthy for routine physical examination. Med-Team benefits are coordinated by a special unit located at union headquarters that acts as liaison between members and health care providers.

Participating physicians and practitioners are skillful, caring providers that have agreed to work as a "team" in providing care to eligible DC 37 members and their families. Members choose their primary care physician (family practice, general medicine, pediatrics or ob/gyn) who will be responsible for managing their care as the leader of a health care team that includes participating specialists, diagnostic facilities, community-based hospitals, and the union's Member Relations Unit which can help Med-Team members with any problems they may have.

Primary care physicians see Med-Team members in private offices or in group practices, depending on the doctor selected or the borough where you choose to receive your care.

A \$10 copayment is required when visiting a primary care physician or specialist.

Med-Team services are provided at conveniently located sites, easy to reach by public transportation or car.

DC 37 Med-Team members must call TEAMCARE whenever hospitalization is needed or certain surgical procedures are recommended. TEAMCARE offers assistance to members by:

explaining the various health care options available; helping the member choose the appropriate health care setting (hospital or outpatient department) or service (for example, home care); and while in the hospital, making sure that the stay lasts only as long as medically necessary. Failure to call TEAMCARE may result in a copayment of up to \$250 per hospital admission. Medicare-eligible retirees and dependents with primary coverage other than Med-Team are not required to call TEAMCARE.

If you choose a non-participating provider, Med-Team will reimburse you according to a reduced fee schedule. This means there will be out-of-pocket costs for which the member is responsible. There is no deductible requirement.

MED-TEAM MEDICARE

Retirees with Medicare Parts A and B enjoy the benefit of having all coinsurance and deductibles covered by Med-Team. In addition to supplementing payment for Medicare covered services, Med-Team also provides coverage for routine physical examinations when using a Med-Team physician. See pages 32 and 33 for additional information on the Med-Team Medicare Program.

COST

There are no payroll or pension deductions for the basic Med-Team Program. There is no Optional Rider.

You may contact the plan at:

**125 Barclay Street, 3rd Floor
New York, NY 10007
(212) 815-1313**

DC 37 MED-TEAM

OUTPATIENT CARE		Coverage
PHYSICIANS' OFFICE VISITS		*\$10 copayment
SURGERY—PHYSICIAN'S OFFICE OR HOSPITAL OUTPATIENT		
LABORATORY AND X-RAY SERVICES		*Covered in full
HOSPITAL CARE		*Covered in full
SEMI-PRIVATE ROOM AND BOARD		Covered in full
PHYSICIANS' AND SURGEONS' SERVICES		*Covered in full
GENERAL NURSING CARE		Covered in full
DRUGS AND MEDICATION		Covered in full
DIAGNOSTIC SERVICES (LAB WORK, X-RAYS)		*Covered in full
INTENSIVE AND CORONARY CARE UNITS		Covered in full
USE OF OPERATING AND RECOVERY ROOM		Covered in full
ANESTHESIA		*Covered in full
EMERGENCY CARE		
AMBULANCE SERVICE		Covered for \$150
DOCTORS' OFFICES		*\$10 copayment
HOSPITAL EMERGENCY ROOM		*Covered by Empire Blue Cross and Blue Shield within 12 hours of an illness or 72 hours of an accident
		Covered in full when authorized by a Med-Team physician
URGENT CARE FACILITY		
PREVENTIVE CARE		**\$10 copayment
ROUTINE PHYSICAL CHECK-UP		**\$10 copayment
ROUTINE PEDIATRIC (WELL-BABY) CARE		**\$10 copayment
IMMUNIZATIONS		Not Covered (Covered through DC 37 Health and Security Plan)
ROUTINE HEARING EXAMS / VISION CARE		
MENTAL HEALTH AND CHEMICAL DEPENDENCY CARE		
OUTPATIENT	CHEMICAL DEPENDENCY	***Covered in full, 60-visit combined annual maximum for drug and/or alcohol treatment in a Med-Team approved facility
		Not Covered
INPATIENT	MENTAL HEALTH CHEMICAL DEPENDENCY	***Detoxification: Covered in full; 30-day combined annual maximum for drug, alcohol, and/or mental health treatment
		Rehabilitation: Not Covered
		Physician: Covered in full
		Hospitalization: 30 days per 12- month period in a psychiatric section of an approved general hospital (government facilities not covered); 30-day combined annual maximum for drug, alcohol, and/or mental health treatment
MATERNITY CARE		
IN PHYSICIANS' OFFICES		
PRENATAL AND POSTNATAL VISITS		*Covered in full
IN THE HOSPITAL		
PHYSICIANS' SERVICES—MOTHER AND NEWBORN		Covered in full
NEWBORN NURSERY SERVICES		Covered in full
MOTHER'S HOSPITAL SERVICES		Covered in full
HOME HEALTH CARE		
HOME CARE SERVICES		
HOSPICE CARE		*Covered in full 200 visits per year
SKILLED NURSING FACILITY		*Covered in full 210 days
REHABILITATION		Not Covered
PHYSICAL THERAPY		*Covered for 30 days total in- or outpatient in a calendar year. Inpatient physical therapy/rehabilitation (PT/R) is covered in full if PT/R is rendered concurrently with other medical care. If medical care ceases and the hospital stay is for PT/R, that portion of the stay is not covered.
		*Covered for 16 days total in- or outpatient in a calendar year
		Covered through DC 37 Health and Security Plan
		Covered to age 23 with proof of student status
SPEECH		
PHARMACY SERVICES		
FULL-TIME STUDENTS		

*When using a Med-Team physician or authorized by a Med-Team physician (partial reimbursement for use of non-Med-Team services).

**Covered only when using a Med-Team physician.

***When provided or authorized by a Med-Team physician, or referred by the Employee Assistance Program (EAP).

METROPOLITAN HEALTH PLAN / HMO

Metropolitan Health Plan/HMO is open to Health and Hospitals Corporation (HHC) employees, non-Medicare eligible retirees, and their dependents, including full-time students up to age 23.

Metropolitan Health Plan (MHP/HMO) is a pre-paid health plan developed by the NYC Health and Hospitals Corporation in partnership with Metropolitan Hospital Center and New York Medical College. The MHP/HMO physicians are based at Metropolitan Hospital Center, 1901 First Avenue in Manhattan, between 97th and 99th Streets. MHP/HMO offers its members comprehensive health care benefits and the convenience of receiving both medical and hospital services at one location. MHP/HMO members receive care in newly-renovated inpatient and outpatient care areas.

As an MHP/HMO member you will select a primary care physician from a panel of MHP/HMO physicians. The physician you select provides and coordinates all your health care needs. A primary care provider facilitates continuity of care and access to specialty care. All MHP/HMO physicians are board-certified or board-eligible in their medical specialties and are on the faculty of New York Medical College.

As a member of MHP/HMO you will be covered for all hospital and surgical costs. Routine, urgent, and emergency visits, and specialty care are covered in full when using the MHP/HMO facility. There are no copayments, no deductibles, no bills for covered services, and there is no waiting for reimbursement.

If a member needs medical or hospital care which cannot be provided at Metropolitan Hospital Center, or if an emergency occurs outside the MHP/HMO service area, MHP/HMO covers these in full.

Other special features of MHP/HMO include a 24-hour, seven-day-a-week hotline (212) 230-7000 staffed by registered nurses with on call physicians who provide help or advice for emergencies or any medical problem; an on-site membership services staff who help with orienting members, answering questions and handling any member problems or concerns; and a health educator who gives individual and group sessions on a variety of health education issues.

OPTIONAL RIDER

Metropolitan Health Plan offers an Optional Rider which provides full coverage for prescription drugs when prescribed by an MHP/HMO physician. When ordered by Metropolitan Health Plan, private duty nursing in the hospital and covered appliances and prosthetics are also covered under the rider. If your welfare fund provides benefits similar to those listed in the rider, those specific benefits will be provided through your welfare fund and your payroll deductions will be reduced accordingly.

METROPOLITAN HEALTH PLAN MEDICARE

Metropolitan Health Plan/HMO is not offered to Medicare-eligible retirees.

COST

All plan costs are noted on page 45.

You may contact the health plan at:

**Metropolitan Hospital Center
1901 First Avenue
New York, NY 10029
(212) 230-6334**

METROPOLITAN HEALTH PLAN

OUTPATIENT CARE		Coverage
PHYSICIANS' OFFICE VISITS		*Covered in full
SURGERY—PHYSICIAN'S OFFICE OR HOSPITAL OUTPATIENT		*Covered in full
LABORATORY AND X-RAY SERVICES		*Covered in full
HOSPITAL CARE		
SEMI-PRIVATE ROOM AND BOARD		*Covered in full
PHYSICIANS' AND SURGEONS' SERVICES		*Covered in full
GENERAL NURSING CARE		*Covered in full
DRUGS AND MEDICATION		*Covered in full
DIAGNOSTIC SERVICES (LAB WORK, X-RAYS)		*Covered in full
INTENSIVE AND CORONARY CARE UNITS		*Covered in full
USE OF OPERATING AND RECOVERY ROOM		*Covered in full
ANESTHESIA		*Covered in full
EMERGENCY CARE		
AMBULANCE SERVICE		*Covered in full
DOCTORS' OFFICES		*Covered in full
HOSPITAL EMERGENCY ROOM		*Covered in full
URGENT CARE FACILITY		*Covered in full
PREVENTIVE CARE		
ROUTINE PHYSICAL CHECK-UP		*Covered in full
ROUTINE PEDIATRIC (WELL-BABY) CARE		*Covered in full
IMMUNIZATIONS		*Covered in full
ROUTINE HEARING EXAMS / VISION CARE		*Covered in full
MENTAL HEALTH AND CHEMICAL DEPENDENCY CARE		
OUTPATIENT	CHEMICAL DEPENDENCY	**Covered in full, 60-visit per calendar year combined maximum for drug and/or alcohol treatment
	MENTAL HEALTH	*Covered for one visit per calendar year for diagnostic purposes
INPATIENT	CHEMICAL DEPENDENCY	**Detoxification: Covered in full; 30-day combined annual maximum for drug, alcohol, and/or mental health treatment
	MENTAL HEALTH	Rehabilitation: Not Covered
		*Covered in full 30 days (professional component not covered); 30-day combined annual maximum for drug, alcohol, and/or mental health treatment
MATERNITY CARE		
IN PHYSICIANS' OFFICES		
PRENATAL AND POSTNATAL VISITS		*Covered in full
IN THE HOSPITAL		
PHYSICIANS' SERVICES—MOTHER AND NEWBORN		*Covered in full
NEWBORN NURSERY SERVICES		*Covered in full
MOTHER'S HOSPITAL SERVICES		*Covered in full
HOME HEALTH CARE		
HOME CARE SERVICES		
HOSPICE CARE		*Intermittent Nursing Service—Covered in full
SKILLED NURSING FACILITY		Not Covered
		*Covered in lieu of hospitalization when medically necessary
REHABILITATION		
PHYSICAL		*Covered in full short term
SPEECH		Not Covered
PHARMACY SERVICES		See Optional Rider
FULL-TIME STUDENTS		Covered to age 23

*When provided or authorized by a Metropolitan Health Plan/HMO doctor.

**When provided or authorized by a Metropolitan Health Plan/HMO doctor, or referred by the Employee Assistance Program (EAP).

MID-HUDSON HEALTH PLAN

This plan is open only to employees and retirees residing in Columbia, Greene, Delaware, and Ulster Counties and a portion of Northern Dutchess County including Red Hook and Rhinebeck. Medicare-eligibles can join this plan.

The Mid-Hudson Health Plan (MHP) is a network-model Health Maintenance Organization (HMO), offering its members the opportunity to receive health care services at a participating physician's private office. Each MHP member selects his or her own personal care physician, thereby maintaining the traditional doctor/patient relationship. Physician visits require a \$3 copayment.

As an MHP member you and each member of your family will choose a personal care physician from MHP's list of participating providers. For adults, the personal care physician will specialize in either internal medicine or family practice; for children, specialization will be in either pediatrics or family practice. Your personal care physician is your key to the Mid-Hudson Health Plan. He or she will coordinate all health care services, including referrals which must be arranged and authorized by your personal care physician. In this way, MHP is able to meet all your health care needs.

MHP members receive full coverage for inpatient hospital care when arranged for and authorized by their personal care physicians. Most inpatient care will be provided at the following hospitals: Benedictine Hospital (Kingston); Columbia Memorial Hospital (Hudson); Ellenville Hospital (Ellenville); Kingston Hospital (Kingston); Margaretville Hospital (Margaretville); Memorial Hospital and Nursing Home of Greene County (Catskill); Northern Dutchess Hospital (Rhinebeck); St. Francis Hospital (Poughkeepsie); and Vassar Hospital (Poughkeepsie). Specialized care not available in local hospitals may be referred to Mid-Hudson's tertiary medical centers: New York Medical College/Westchester County Medical Center (Valhalla), and Albany Medical Center (Albany). In addition medically necessary services not provided by these hospitals or MHP affiliated providers will be arranged by your personal care physician and covered in full.

Emergency care is covered, provided that the services are authorized by your MHP personal care physician. For life-threatening emergencies, members receive immediate care and then are expected to call their MHP physician within 48 hours of receiving care. Members are covered 24 hours a day, 7 days a week. Emergency care is covered anywhere in the world. There is a \$25 copayment, for each emergency room visit.

MHP care is comprehensive. Routine health care, office visits, allergy tests and treatment, eye and ear exams, laboratory services,

X-rays, diagnostic tests, second surgical opinions, medical social services, health education, well-baby care, well-child care, prenatal and post-natal care, services of a physician, surgeon, anesthesiologist, emergency services, skilled nursing care, mental health care, physical therapy and rehabilitation are all covered.

Mid-Hudson basic benefits are expanded to include vision care. In addition to a vision exam each year, each member is entitled to one pair of prescription eyeglasses every two years for a \$25 copayment, or an allowance toward the cost of contact lenses.

Unmarried, full-time student dependents are covered to age 25.

MEDICARE COVERAGE

If you are retired with both Medicare Parts A and B you are also eligible for MHP. This plan provides the same comprehensive benefits of the standard MHP program, and includes coverage for deductibles, coinsurance, and services not covered by Medicare Parts A and B, but not to exceed the standard coverage provided through MHP's program. To be covered in full, Medicare eligibles must use MHP Physicians. If a non-MHP physician is used, only Medicare coverage is applicable and care is subject to deductibles, copayment, and exclusions. See Pages 32 and 33 for additional information on the MHP Medicare program.

Employees or retirees who have questions about this coverage may contact the MHP Member Services Department at the telephone number below.

OPTIONAL RIDER

A prescription drug rider, requiring a \$3 copayment per prescription at a participating pharmacy, is available.

Prescriptions will be dispensed on a generic basis. Those members requesting a brand-name drug must pay the difference between the brand and the generic instead of the \$3 co-pay.

COST

Please see page 45 for more information on payroll or pension deductions.

You may contact the health plan at:

**Park West Office Complex
Hurley Avenue Extension
Kingston, NY 12401
(914) 338-0202
(800) 443-4711**

MHP has established a hotline number (800) 443-4711, exclusively for City of New York employees and retirees to obtain additional information.

MID-HUDSON HEALTH PLAN

OUTPATIENT CARE

PHYSICIANS' OFFICE VISITS
SURGERY—PHYSICIAN'S OFFICE OR
HOSPITAL OUTPATIENT
LABORATORY AND X-RAY SERVICES

Coverage
*\$3 copayment
*\$3 copayment
*Covered in full

HOSPITAL CARE

SEMI-PRIVATE ROOM AND BOARD
PHYSICIANS' AND SURGEONS' SERVICES
GENERAL NURSING CARE
DRUGS AND MEDICATION
DIAGNOSTIC SERVICES (LAB WORK, X-RAYS)
INTENSIVE AND CORONARY CARE UNITS
USE OF OPERATING AND RECOVERY ROOM
ANESTHESIA

*Covered in full
*Covered in full
*Covered in full
*Covered in full
*Covered in full
*Covered in full
*Covered in full
*Covered in full

EMERGENCY CARE

AMBULANCE SERVICE
DOCTORS' OFFICES
HOSPITAL EMERGENCY ROOM
URGENT CARE FACILITY

*Covered in full
*Covered in full
*\$25 copayment (waived if admitted to hospital)
*\$25 copayment

PREVENTIVE CARE

ROUTINE PHYSICAL CHECK-UP
ROUTINE PEDIATRIC (WELL-BABY) CARE
IMMUNIZATIONS
ROUTINE HEARING EXAMS / VISION CARE

*\$3 copayment
*\$3 copayment
*\$3 copayment
*\$3 copayment (\$25 copayment for prescription eyeglasses when medically necessary)

MENTAL HEALTH AND CHEMICAL DEPENDENCY CARE

OUTPATIENT CHEMICAL DEPENDENCY

MENTAL HEALTH

**\$3 copayment, 60-visit combined annual maximum for drug and/or alcohol treatment
*Maximum 20 visits per member per contract year: visits 1 – 5: \$3 copayment per visit, visits 6 – 20: \$10 copayment per visit

INPATIENT CHEMICAL DEPENDENCY

MENTAL HEALTH

**Detoxification: Covered in full; 30-day combined annual maximum for drug and/or alcohol treatment
*Rehabilitation: Covered in full; 30-day combined annual maximum for drug and/or alcohol treatment
*Covered in full; 30-day annual maximum

MATERNITY CARE

IN PHYSICIANS' OFFICES
PRENATAL AND POSTNATAL VISITS
IN THE HOSPITAL
PHYSICIANS' SERVICES—MOTHER AND NEWBORN
NEWBORN NURSERY SERVICES
MOTHER'S HOSPITAL SERVICES

*\$3 copayment
*Covered in full
*Covered in full
*Covered in full

HOME HEALTH CARE

HOME CARE SERVICES
HOSPICE CARE

*Covered in full
*Covered in full up to 210 days when certified as appropriate
*Covered in full when medically appropriate

SKILLED NURSING FACILITY

REHABILITATION

PHYSICAL

*Covered in full, 60-day maximum, inpatient and outpatient

SPEECH

*Evaluation only—Covered in full

PHARMACY SERVICES

FULL-TIME STUDENTS

See Optional Rider
Covered to age 25

* When using Mid-Hudson physicians or referred by a Mid-Hudson physician.

** When using Mid-Hudson physicians or referred by a Mid-Hudson physician, or referred by the Employee Assistance Program (EAP).

SANUS HEALTH PLAN

SANUS HEALTH PLAN, a subsidiary of the New York Life Insurance Company, is pleased to once again offer to City of New York employees and retirees a high quality, comprehensive health care plan. As one of the largest managed health care companies in New York and the nation, SANUS provides services to over 600,000 individuals through a network of over 15,000 private physicians.

SANUS has over 2,500 physicians and 83 prestigious hospitals participating in the greater New York metropolitan area. Our hospital network includes, but is not limited to, in New York: Beth Israel, Columbia Presbyterian, Mount Sinai, New York Hospital, Montefiore, Brookdale, Long Island College, Maimonides, Staten Island, Long Island Jewish, Catholic Medical Center and Flushing Hospitals; and in New Jersey: Overlook Hospital, Saint Barnabas, Newark Beth Israel, Morristown Memorial, Pascack Valley and Meadowlands Hospitals. All participating physicians are board certified or board eligible and practice in their own private offices. This insures that you and your family will receive personalized high-quality medical care. Please see the SANUS directory of private doctors for additional hospitals and doctors.

SANUS is licensed to provide services in the following areas: in New York State: New York City, Nassau, Suffolk, Westchester, Orange, Putnam and Rockland counties; in New Jersey: Bergen, Essex, Hudson, Morris, Passaic, and Union counties. The Washington D.C. plan, Health Plus, is available to City of New York employees and retirees. Coverage is also available to retirees living in certain areas of Missouri and Texas. (See Expanded Service Area.)

Each SANUS member will choose a personal doctor who is either an internist, family practitioner or a pediatrician. Additionally, each female member 18 years of age or older may choose a SANUS gynecologist, on an annual basis, for a complete Well-Woman Examination.

You may schedule an appointment to see the physician you have personally selected whenever you need medical care. Your primary care provider is responsible for arranging all your health care services, including specialist visits and elective hospital admissions. You know in advance that SANUS not only covers your health care needs but also stresses preventive care.

When you see your primary care doctor, you pay only \$5. This includes all labs, x-rays and tests. Well-baby care doctor visits are covered without the \$5 copayment for the first year. SANUS pays 100% for all specialty care, hospitalization, surgery and anesthesia when authorized by your primary care doctor. Emergency care is covered anywhere in the world.

In case of a medical emergency, if you are unable to use a plan hospital, SANUS will arrange to directly pay the non-plan hospital or physician, or reimburse the member. Members must notify SANUS within 24 hours of the onset of the emergency for authorization. There is a \$40 copayment for each emergency room visit, which is waived if you are admitted to the hospital.

SANUS HEALTH PLAN HEALTHY DISCOUNT PROGRAM

As a member of SANUS, you can enjoy the unique HEALTHY DISCOUNT PROGRAM which is part of the basic package. This includes: DENTAL DISCOUNTS, DISCOUNT FITNESS AND

WEIGHT REDUCTION PROGRAMS, ANNUAL VISION EXAMINATIONS, ANNUAL PHYSICAL EXAMS, WOMEN'S WELLNESS PROGRAM, AND DISCOUNT CONTACT LENS REPLACEMENTS.

SANUS MEDICARE

If you are retired with both Medicare Parts A and B, you are also eligible for the SANUS Medicare program. This plan includes coverage for the deductibles, coinsurance, and services not covered by Medicare Parts A and B, but will not exceed the coverage provided through the standard SANUS plan. To be covered in full, Medicare-eligible members must use SANUS physicians. If a non-SANUS physician is used, only Medicare coverage is applicable and care is subject to deductibles, coinsurance, and exclusions. See pages 32 and 33 for additional information on the SANUS Medicare program.

EXPANDED SERVICE AREA FOR RETIREES

SANUS is available to retirees living in Houston and Dallas/Ft. Worth, Texas; St. Louis, Missouri; and the Washington, D.C. area. The plan is available to both non-Medicare and Medicare-eligible retirees. While the plan benefits in these locations are similar to the benefits offered in New York, there are some differences in copayments and deductibles.

More information can be obtained by calling the area office directly.

In Houston, Texas	Telephone (713) 993-9982 (800) 833-5318
In Dallas/Ft. Worth, Texas	Telephone (214) 621-0557 (800) 486-3040
In St. Louis, Missouri	Telephone (314) 434-6114 (800) 627-6010
In Washington, D.C.	Telephone (301) 441-1600 (800) 635-3121

OPTIONAL RIDER

An Optional Rider for prescription drugs is also available to SANUS members. Mail service (maintenance) drugs are provided at no charge. There is a \$50 deductible for non-mail service (non-maintenance) drugs per individual, per year. After the deductible is satisfied, there is a \$3 charge per prescription or refill. SANUS has over 300 participating pharmacies you may use, including but not limited to Pathmark and CVS.

COST

Please see page 45 for more information on payroll or pension deductions.

You may contact the health plan at:

75-20 Astoria Boulevard
Jackson Heights, New York 11370
(718) 899-3600

For additional information: From (212) and (718) area codes call (718) 899-3600. From all other area codes call 1-800-338-8113.

SANUS HEALTH PLAN

OUTPATIENT CARE

PHYSICIANS' OFFICE VISITS

SURGERY—PHYSICIAN'S OFFICE OR
HOSPITAL OUTPATIENT
LABORATORY AND X-RAY SERVICES

HOSPITAL CARE

SEMI-PRIVATE ROOM AND BOARD
PHYSICIANS' AND SURGEONS' SERVICES
GENERAL NURSING CARE
DRUGS AND MEDICATION
DIAGNOSTIC SERVICES (LAB WORK, X-RAYS)
INTENSIVE AND CORONARY CARE UNITS
USE OF OPERATING AND RECOVERY ROOM
ANESTHESIA

EMERGENCY CARE

AMBULANCE SERVICE
DOCTORS' OFFICES
HOSPITAL EMERGENCY ROOM
URGENT CARE FACILITY

PREVENTIVE CARE

ROUTINE PHYSICAL CHECK-UP
ROUTINE PEDIATRIC (WELL-BABY) CARE
IMMUNIZATIONS
ROUTINE HEARING EXAMS / VISION CARE

MENTAL HEALTH AND CHEMICAL DEPENDENCY CARE

OUTPATIENT CHEMICAL DEPENDENCY

INPATIENT MENTAL HEALTH
 CHEMICAL DEPENDENCY

MENTAL HEALTH

MATERNITY CARE

IN PHYSICIANS' OFFICES
 PRENATAL AND POSTNATAL VISITS
IN THE HOSPITAL
 PHYSICIANS' SERVICES—MOTHER
 PHYSICIANS' SERVICES—NEWBORN
 NEWBORN NURSERY SERVICES
 MOTHER'S HOSPITAL SERVICES

HOME HEALTH CARE

HOME CARE SERVICES
HOSPICE CARE

SKILLED NURSING FACILITY

REHABILITATION

PHYSICAL
SPEECH

DENTAL

PHARMACY SERVICES

FULL-TIME STUDENTS

Coverage

*Covered in full—except for a \$5 copayment for primary care physician only

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*\$10 copayment for primary care physician only

*\$40 copayment (waived if admitted to hospital)
\$20 copayment

*\$5 copayment

*\$5 copayment

*\$5 copayment

*\$5 copayment

**Covered in full, 60-visit combined annual maximum for drug and/or alcohol treatment

*50% copayment for up to 20 visits annually

*Detoxification: Covered in full; 30-day combined annual maximum for drug and/or alcohol treatment

Rehabilitation: Not Covered

*Covered in full; 30-days inpatient or 60 days in a day care program

*Covered in full

*Covered in full

*Covered in full

*\$50 copayment per day

*Covered in full

*Covered in full

Not Covered

*Covered in full

*Covered in full—short term rehabilitation only

*Covered in full—short term rehabilitation only

***Covered according to Fee Schedule

See Optional Rider

Covered to age 23

*When provided or authorized by a SANUS physician.

**When provided or authorized by a SANUS physician, or referred by the Employee Assistance Program (EAP).

***Refer to the SANUS Benefit Booklet for details.

US HEALTHCARE

US HEALTHCARE is a comprehensive health care plan which does more than simply pay the bills for your medical costs. US HEALTHCARE has over 16 years of experience in providing quality health care to over one million people in the United States. Personal care is provided through family doctors located throughout New York (the five boroughs, Nassau, Suffolk, Orange, Putnam, Rockland and Westchester counties); the entire state of New Jersey; Pennsylvania (Southeastern Pennsylvania, Berks, Montgomery, Chester, Delaware, Philadelphia, Lehigh Valley and Bucks counties); Pittsburgh (Butler, Beaver, Allegheny, Westmoreland, Washington and Fayette counties); Connecticut (Fairfield, New Haven, Litchfield and Hartford counties); Delaware (Kent and New Castle counties); and Massachusetts (Essex, Middlesex, Suffolk, Norfolk and Plymouth counties). Also, the service area has been expanded to include Bristol, Barnstable and Worcester counties in Massachusetts, and Hillsborough and Rockingham counties in New Hampshire.

When you become a member of US HEALTHCARE, you and members of your family will be able to pick a family doctor, internist or pediatrician from a list of 3,700 primary care doctors in the service area from the US HEALTHCARE directory of Participating Physicians. As a special service to our female members, women age 17 or older are eligible to receive a yearly routine gynecological exam either by the primary care physician or by a participating US HEALTHCARE gynecologist. Once you have selected a doctor, you will go to his or her office to receive the care you need. If you should need a specialist, the primary care doctor you have chosen will refer you and all visits are completely covered. Care will be coordinated between your primary care doctor and the specialist.

When you visit your primary care doctor, you will pay \$2 for that visit. Specialty care, hospitalization, surgery, intensive care, ambulance service, physical or rehabilitation therapy, home care, allergy treatments, vision or hearing examinations, anesthesia, diagnostic tests and X-rays are covered when medically necessary with a written referral from your primary care physician. Mental health and substance abuse benefits are also offered. There are no claim forms to fill out and there is no waiting for reimbursement.

Emergency care is covered anywhere in the world and all reasonable costs are reimbursed at 100%, except for a copayment of \$5 for a visit to the doctor's office or \$15 for a visit to an emergency room. If you are admitted to the hospital, the emergency room copayment is waived.

Preventive dental care is also available for children under the age of twelve. It includes examination, cleaning, instruction in dental care, and fluoride treatments. Adults are covered for the removal of bony impacted wisdom teeth.

If you or someone in your family is faced with a rare or complicated illness, US HEALTHCARE's National Medical Excellence ProgramSM will help you find appropriate medical care available at leading medical facilities located throughout the United States and provides 100% coverage.

For early detection of breast and colorectal cancer, our US Healthcare CheckTM Program offers free mammographies and colorectal screening test kits to all eligible members.

As a member of US HEALTHCARE, you will be able to take advantage of the Healthy Outlook Programs, which include the Healthy Breathing Program to help you stop smoking, Fitness Reimbursement Program which pays you to exercise, Stress

Management, and the Healthy Eating Program to help lose and maintain your weight.

For more details on benefits and special programs, you may refer to information on the next page and to material included in US HEALTHCARE's Benefits and Directory booklet which will be available during the Transfer Period or by calling the telephone numbers below. You will also need to pick a primary care physician and pharmacy, if it applies, for every family member on the City of New York Health Benefits Applications (Forms EB 88 and P2r).

US HEALTHCARE MEDICARE

The US HEALTHCARE Medicare Program is a risk plan only available to retirees living in New York (Orange, Putnam, Westchester, Suffolk, Nassau, Rockland and the five boroughs) and Pennsylvania (Philadelphia and Pittsburgh areas).

If you are retired with Medicare Parts A and B, you may join US HEALTHCARE's Medicare Program. US HEALTHCARE becomes your exclusive coverage for Medicare benefits. It is not a supplemental plan and no other supplemental coverage is necessary. Retired Medicare eligibles will receive their health care as described above with expanded coverage to include durable medical equipment and hearing aids. There are no deductibles, no claim forms to file, and no coinsurance. All medical care must be coordinated by your US HEALTHCARE participating primary care physician and received from providers participating in the US HEALTHCARE network. Medical care received outside the US HEALTHCARE system is not covered by US HEALTHCARE or Medicare, except in an emergency situation.

The US HEALTHCARE Premier Plan, is only available to retirees living in New Jersey, Connecticut, and Pennsylvania. US HEALTHCARE will provide a health plan with comprehensive hospital and medical benefits. All members must have Medicare Parts A and B to participate in the program. US HEALTHCARE will not pay for services provided by a non-participating provider except for emergencies. All non-emergency care must be coordinated by the primary care physician.

Please see pages 32 and 33 for more information on the US HEALTHCARE Medicare Programs. There is a separate listing of participating physicians and benefits for US HEALTHCARE's Medicare programs. Please call our Solutions number at 1-800-282-5366 for the current Medicare primary physician list and more detailed information on US HEALTHCARE's Medicare benefits.

OPTIONAL RIDER

An Optional Rider is available, covering prescription drugs for a \$2.50 copayment per prescription at a participating pharmacy.

COST

Please see page 45 for more information on payroll or pension deductions.

You may contact the plan with any questions at the Solutions number, (212) 286-8670 or 1-800-445-USHC, or by writing to:

US HEALTHCARE
Metropolitan Executive Towers, Suite 800
One Meadowlands Plaza
East Rutherford, NJ 07073

US HEALTHCARE

OUTPATIENT CARE		Coverage
PHYSICIANS' OFFICE VISITS		*Covered in full—except for a \$2 copayment for primary care physician only
SURGERY—PHYSICIAN'S OFFICE OR HOSPITAL OUTPATIENT		*Covered in full
LABORATORY AND X-RAY SERVICES		*Covered in full
HOSPITAL CARE		
SEMI-PRIVATE ROOM AND BOARD		*Covered in full
PHYSICIANS' AND SURGEONS' SERVICES		*Covered in full
GENERAL NURSING CARE		*Covered in full
DRUGS AND MEDICATION		*Covered in full
DIAGNOSTIC SERVICES (LAB WORK, X-RAYS)		*Covered in full
INTENSIVE AND CORONARY CARE UNITS		*Covered in full
USE OF OPERATING AND RECOVERY ROOM		*Covered in full
ANESTHESIA		*Covered in full
EMERGENCY CARE		
AMBULANCE SERVICE		*Covered in full when medically necessary
DOCTORS' OFFICES		\$5 copayment
HOSPITAL EMERGENCY ROOM		*\$15 copayment (waived if admitted to hospital)
URGENT CARE		Not covered
PREVENTIVE CARE		
ROUTINE PHYSICAL CHECK-UP		*\$2 copayment
ROUTINE PEDIATRIC (WELL-BABY) CARE		*\$2 copayment
IMMUNIZATIONS		*\$2 copayment (except for travel)
ROUTINE HEARING EXAMINATIONS/VISION CARE		*\$2 copayment
MENTAL HEALTH AND CHEMICAL DEPENDENCY CARE		
OUTPATIENT	CHEMICAL DEPENDENCY	**\$2 copayment per visit, 60-visit combined annual maximum for drug and/or alcohol treatment *Covered for 20 visits; first 2 covered in full; next 18 with variable copayment from \$10 to \$25 **Detoxification: Covered in full for acute phase of treatment Rehabilitation: Not Covered *Covered 35 days per 365-day period
	MENTAL HEALTH	
INPATIENT	CHEMICAL DEPENDENCY	
	MENTAL HEALTH	
MATERNITY CARE		
IN PHYSICIANS' OFFICES		*Covered in full
PRENATAL AND POSTNATAL VISITS		
IN THE HOSPITAL		
PHYSICIANS' SERVICES—MOTHER AND NEWBORN		*Covered in full
NEWBORN NURSERY SERVICES		*Covered in full
MOTHER'S HOSPITAL SERVICES		*Covered in full
HOME HEALTH CARE		
HOME CARE SERVICES		*Covered in full when medically necessary
HOSPICE CARE		*Covered in full when medically necessary
SKILLED NURSING FACILITY		*Covered in full when medically necessary
REHABILITATION		
PHYSICAL		*Covered in full—short-term rehabilitation
SPEECH		*Covered in full—short-term rehabilitation
DENTAL		
PHARMACY SERVICES		**Preventive care for children under 12
FULL-TIME STUDENTS		See Optional Rider
		Covered to age 23

*When provided or authorized by a participating primary care physician.

**When provided or authorized by a participating primary care physician or referred by Employee Assistance Program (EAP).

***Refer to US HEALTHCARE's Benefits and Directory Booklet.

WELLCARE OF NEW YORK

This plan is open only to employees and retirees residing in the counties of Albany, Columbia, Dutchess, Greene, Orange, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Sullivan, Ulster, Warren, and Washington. Medicare-eligibles can join this plan.

WellCare of New York (WellCare) is a Health Maintenance Organization (HMO), offering its members the opportunity to receive health care services at a participating physician's private office. Each WellCare member selects his or her own personal care physician, thereby maintaining the traditional doctor/patient relationship. Physician visits require a \$3 copayment.

As a WellCare member you and each member of your family will choose a personal care physician from WellCare's list of participating providers. For adults, the personal care physician will specialize in either internal medicine or family practice and for children, specialization will be in either pediatrics or family practice. Your personal care physician is your key to WellCare of New York. He or she will coordinate all health care services, including referrals which must be arranged for and authorized by your personal care physician. In this way, WellCare is able to meet all your health care needs.

WellCare members receive full coverage for inpatient hospital care when arranged for and authorized by their personal care physician. Most inpatient care will be provided at the hospital(s) where your Primary Care Physician or Specialist has admitting privileges, including all hospitals in the WellCare service area. Specialized care not available in local hospitals may be referred to WellCare's tertiary medical centers: New York Medical College/Westchester County Medical Center (Valhalla), and Albany Medical Center (Albany). In addition, medically necessary services not provided by these hospitals or WellCare affiliated providers will be arranged by your personal care physician and covered in full.

Emergency care is covered, provided that the services are authorized by your WellCare personal care physician. For life-threatening emergencies, members receive immediate care and then are expected to call their WellCare physician within 48 hours of receiving care. Members are covered 24 hours a day/7 days a week. Emergency care is covered anywhere in the world. There is a \$25 copayment for each emergency room visit.

WellCare care is comprehensive. Routine health care, office visits, allergy tests and treatment, eye and ear exams, laboratory services, X-rays, diagnostic tests, second surgical opinions, medical social services, health education, well-baby and well-child care, prenatal and postnatal care, services of a physician, surgeons, anesthesiologist, emergency services, skilled nursing care, mental health care, physical therapy and rehabilitation are all covered.

WellCare basic benefits are expanded to include vision care. In addition to a vision exam each year, each member is entitled to one pair of prescription eyeglasses every two years for a \$25 copayment, or an allowance toward the cost of contact lenses. Unmarried, full-time student dependents are covered to age 25.

WOMEN'S HEALTH RESOURCE CENTER

One phone call puts WellCare members in touch with a resource service dealing with the many issues facing women in regard to their health and well-being. The Resource Center is able to provide individual patient education and case management to coordinate care. In addition, female members receive direct access to a contracted OB/GYN for their annual check-up and can be referred to a mammography center to receive a mammogram.

MENTAL HEALTH RESOURCES AND REFERRAL CENTER

WellCare members can be connected with a mental health professional who can evaluate, direct, coordinate, and review the member's mental health needs. Assistance can be given in dealing with the full range of problems that affect people and how they cope with themselves, their lives, and their jobs.

MEDICARE COVERAGE

If you are retired with both Medicare Parts A and B you are also eligible for WellCare. This plan provides the same comprehensive benefits of the standard WellCare program, and includes coverage for deductibles, coinsurance, and services not covered by Medicare Parts A and B, but not to exceed the standard coverage provided through WellCare's program. To be covered in full, Medicare-eligibles must use WellCare physicians. If a non-WellCare physician is used, only Medicare coverage is applicable and care is subject to deductibles, copayments, and exclusions. See pages 32 and 33 for additional information on the WellCare Medicare program.

Employees or retirees who have questions about this coverage may contact the WellCare Member Services Department at the telephone number below.

OPTIONAL RIDER

A prescription drug rider, requiring a \$3 copayment per prescription at a participating pharmacy is available.

Prescriptions will be dispensed on a generic basis. Those members requesting a brand-name drug must pay the difference between the brand and the generic instead of the \$3 co-pay.

COST

Please see page 45 for more information on payroll or pension deductions.

You may contact the plan at:

**130 Meadow Avenue
Newburgh, New York 12550
(914) 566-0700
(800) 288-5441**

WellCare has established a hotline number (800) 288-5441, exclusively for City of New York employees to obtain additional information.

WELLCARE

OUTPATIENT CARE		Coverage
PHYSICIANS' OFFICE VISITS		*\$3 copayment
SURGERY—PHYSICIAN'S OFFICE OR HOSPITAL OUTPATIENT		*\$3 copayment
LABORATORY AND X-RAY SERVICES		*Covered in full
HOSPITAL CARE		
SEMI-PRIVATE ROOM AND BOARD		*Covered in full
PHYSICIANS' AND SURGEONS' SERVICES		*Covered in full
GENERAL NURSING CARE		*Covered in full
DRUGS AND MEDICATION		*Covered in full
DIAGNOSTIC SERVICES (LAB WORK, X-RAYS)		*Covered in full
INTENSIVE AND CORONARY CARE UNITS		*Covered in full
USE OF OPERATING AND RECOVERY ROOM		*Covered in full
ANESTHESIA		*Covered in full
EMERGENCY CARE		
AMBULANCE SERVICE		*Covered in full
DOCTORS' OFFICES		*Covered in full
HOSPITAL EMERGENCY ROOM		*\$25 copayment waived if admitted to hospital
PREVENTIVE CARE		
ROUTINE PHYSICAL CHECK-UP		*\$3 copayment
ROUTINE PEDIATRIC (WELL-BABY) CARE		*\$3 copayment
IMMUNIZATIONS		*\$3 copayment
ROUTINE HEARING EXAMINATIONS/VISION CARE		*\$3 copayment (\$25 copayment for prescription eyeglasses when medically necessary)
MENTAL HEALTH AND CHEMICAL DEPENDENCY CARE		
OUTPATIENT	CHEMICAL DEPENDENCY	**\$3 copayment, 60-visit combined annual maximum for drug and/or alcohol treatment
	MENTAL HEALTH	*Maximum 20 visits per member per contract year: visits 1 – 5: \$3 copayment per visit, visits 6 – 20: \$10 copayment per visit
INPATIENT	CHEMICAL DEPENDENCY	**Detoxification: Covered in full; 30-day combined annual maximum for drug and/or alcohol treatment
	MENTAL HEALTH	*Rehabilitation: Covered in full; 30-day combined annual maximum for drug and/or alcohol treatment
		*Covered in full; 30-day annual maximum
MATERNITY CARE		
IN PHYSICIANS' OFFICES		
PRENATAL AND POSTNATAL VISITS		*\$3 copayment
IN THE HOSPITAL		
PHYSICIANS' SERVICES—MOTHER AND NEWBORN		*Covered in full
NEWBORN NURSERY SERVICES		*Covered in full
MOTHER'S HOSPITAL SERVICES		*Covered in full
HOME HEALTH CARE		
HOME CARE SERVICES		*Covered in full
HOSPICE CARE		*Covered in full up to 210 days when certified as appropriate
SKILLED NURSING FACILITY		
REHABILITATION		
PHYSICAL		*Covered in full when medically appropriate
SPEECH		*Covered in full, 60-day maximum, inpatient and outpatient
PHARMACY SERVICES		*Evaluation only—Covered in full
FULL-TIME STUDENTS		See Optional Rider
		Covered to age 25

*When using WellCare physicians or referred by a WellCare physician.

**When using WellCare physicians or referred by a WellCare physician, or referred by the Employee Assistance Program (EAP).

COMPARISON OF BENEFITS FOR RETIREES AND THEIR DEPENDENTS COVERED BY MEDICARE

Non HMOs	Medicare Part B Deductible	Office Visit	X-Ray/Lab Test—Outpatient	Specialist Consultations—Out-of-Hospital	Radiation Therapy (Outpatient)
GHI/Empire Blue Cross and Blue Shield Senior Care (GHI-CBP and GHI Type C Enrollees)	Reimburses the \$100 if met by any covered services: in-hospital medical care or out-of-hospital medical care.	Reimburses 20% of the amount approved by Medicare.	Reimburses 20% of the amount approved by Medicare.	Reimburses 20% of the amount approved by Medicare.	Reimburses 20% of the amount approved by Medicare.
ADDITIONAL BENEFITS COVERED UNDER SENIOR CARE INCLUDE: SURGERY, IN-HOSPITAL SPECIALIST CONSULTATIONS, IN-HOSPITAL MEDICAL CARE, ANESTHESIA, AND ASSISTANT AT SURGERY, WHICH ARE REIMBURSED AT 20% OF THE AMOUNT APPROVED BY MEDICARE. HOSPITAL COVERAGE IS PROVIDED BY MEDICARE AND BLUE CROSS: FIRST 60 DAYS COVERED IN FULL; NEXT 180 DAYS PARTIALLY COVERED. OPTIONAL RIDER INCREASES COVERAGE TO 365 DAYS IN FULL.					
Med-Team	Reimburses the \$100 if met by any covered services: in-hospital medical care or out-of-hospital medical care.	Reimburses 20% of the amount approved by Medicare.	Reimburses 20% of the amount approved by Medicare.	Reimburses 20% of the amount approved by Medicare.	Reimburses 20% of the amount approved by Medicare.

HMOs	Medicare Part B Deductible	Office Visit	X-Ray/Lab Test—Outpatient	Specialist Consultations—Out-of-Hospital	Radiation Therapy
CIGNA HEALTHPLAN New York only** Benefits may differ in out-of-area locations. See page 6.	No deductible.	Covered in full.	Covered in full.	Covered in full.	Covered in full.
Empire Blue Cross and Blue Shield HEALTHNET*	No deductible.	Covered in full with a \$5 copayment.	Covered in full.	Covered in full.	Covered in full.
HIP/Medicare Cost Program* (Current NY Members and NJ/Florida Retirees)	No deductible.	Covered in full.	Covered in full.	Covered in full.	Covered in full.
HIP VIP**	No deductible.	Covered in full.	Covered in full.	Covered in full.	Covered in full.
Mid-Hudson*	No deductible.	Covered in full with \$3 copayment.	Covered in full.	Covered in full.	Covered in full.
SANUS HEALTH PLAN* Benefits may differ in out-of-area locations. See Page 26.	No deductible.	Covered in full with \$5 copayment.	Covered in full.	Covered in full.	Covered in full.
US Healthcare* NY and PA only**	No deductible.	Covered in full with \$2 copayment.	Covered in full.	Covered in full.	Covered in full.
WellCare*	No deductible.	Covered in full with \$3 copayment.	Covered in full.	Covered in full.	Covered in full.

ALL HMO PLANS INCLUDE ADDITIONAL BENEFITS PROVIDED IN FULL: SURGERY (IN AND OUT OF HOSPITAL), ANESTHESIA, IN-HOSPITAL CONSULTATIONS, IN-HOSPITAL MEDICAL CARE, HOSPITALIZATION.

*COVERAGE LEVELS INDICATED APPLY ONLY IF CARE IS PROVIDED OR AUTHORIZED BY A PARTICIPATING PHYSICIAN. IF A NON-PARTICIPATING PHYSICIAN IS USED, ONLY MEDICARE BENEFITS APPLY; MEDICARE DEDUCTIBLES, COINSURANCE PAYMENTS, AND EXCLUSIONS ARE IN EFFECT.

**MEDICARE RISK HEALTH PLANS: SEE DEFINITIONS SECTION IN FRONT OF BOOKLET FOR FURTHER EXPLANATION.

NOTE: ALL MEDICAL CARE MUST BE AUTHORIZED BY THE HMO PLAN PHYSICIAN IN ORDER TO BE COVERED IN FULL, EXCEPT IN EMERGENCY CARE SITUATIONS.

COMPARISON OF BENEFITS FOR RETIREES AND THEIR DEPENDENTS COVERED BY MEDICARE

Appliances	Ambulance Service	Private-Duty Nursing	Prescription Drugs	Out-of-Hospital Psychiatric Care	Inpatient Psychiatric Care
Reimburses 20% of the amount approved by Medicare subject to \$25 family deductible per year. (\$2,500 annual max per person, includes private-duty nursing and ambulance benefits).	Same as appliance coverage.	Reimburses 80% subject to same deductible and \$2,500 annual maximum per person as appliance and ambulance coverage.	Coverage available under Optional Rider. 80% reimbursed after \$150 deductible is met; up to \$2,500 per year. Maintenance drugs: \$8 co-pay per prescription. No deductible. No coinsurance.	Not covered.	Reimburses 20% of the amount approved by Medicare.
Reimburses 20% of the amount approved by Medicare.	Reimburses 20% of the amount approved by Medicare.	Reimburses 80% after the first 72 hours when authorized by a physician; subject to a \$100 deductible.	Available through DC-37 Health and Security Plan.	Not covered.	Reimburses 20% of the amount approved by Medicare.

Appliances	Ambulance Service	Private-Duty Nursing	Prescription Drugs	Out-of-Hospital Psychiatric Care	Inpatient Psychiatric Care
Covered in full when medically necessary, coordinated by your CIGNA HEALTHPLAN primary care physician and obtained through designated appliance vendors.	If not an emergency, covered when authorized by a CIGNA HEALTHPLAN primary care physician and approved by the CIGNA HEALTHPLAN Health Services Dept.	Covered in hospital only. Covered in full when prescribed by a CIGNA HEALTHPLAN doctor and medically necessary.	Outpatient drugs \$5 for generic medications and \$15 for brand medications at participating pharmacies. Inpatient drugs covered in full.	No charge for visit 1-2; Visits 3-10: the lesser of \$10 or 50% of visit costs; Visits 11 and over: the lesser of \$25 or 50% of visit costs.	Covered in full for 190 days lifetime maximum when using the CIGNA HEALTHPLAN system.
Covered in full.	Covered in full.	Covered in full.	Coverage available under rider.	Covered in full up to 20 visits per year with \$25 copayment when authorized by a HEALTHNET physician.	Covered up to 30 days when admitted by a HEALTHNET physician.
Covered in full when prescribed by an HIP physician and obtained through HIP designated appliance vendors.	Covered in full.	In-hospital only. Covered in full when prescribed by an HIP physician or in a covered emergency.	Full coverage available under optional drug rider.	Short term therapy covered in full.	Covered in full. (Maximum 190 lifetime days in a psychiatric hospital).
Covered in full when prescribed by an HIP physician and obtained through HIP designated appliance vendors.	Covered in full.	In-hospital only. Covered in full when prescribed by an HIP physician or in a covered emergency.	\$2.50 copayment per 30-day supply	Short term therapy covered in full.	Covered in full. (Maximum 190 lifetime days in a psychiatric hospital).
Reimburses 80% of reasonable and customary charges with a \$1,500 annual maximum.	Covered in full.	Covered in full.	Outpatient \$3 copayment per prescription.	Covered in full up to 20 visits per year with a \$3 copayment when authorized by a MHP physician.	Covered up to 30 days when admitted by a MHP physician.
Covered in full.	If not an emergency, covered when authorized by a Sanus primary care physician and approved by a Sanus Medical Director.	Covered in full.	Coverage available under rider. (\$50 deductible for non-mail service drugs per individual, per year with \$3 copayment per prescription. Maintenance drugs filled at no charge.)	Covered up to 20 visits per year with a 50% copayment when authorized by a Sanus Medical Director.	Covered up to 30 days when admitted by a Sanus physician.
Covered in full when medically necessary and coordinated by US Healthcare Home Care and your primary care physician.	Covered in full.	Covered in full.	Covered under rider (\$2.50 copayment).	Covered for 20 visits, first 2 covered in full—next 18 with a variable copayment of \$10-\$25.	Covered in full for 190 days lifetime maximum when referred by primary care physician.
Reimburses 80% of reasonable and customary charges with a \$1,500 annual maximum.	Covered in full.	Covered in full.	Outpatient \$3 copayment per prescription.	Covered in full up to 20 visits per year with a \$3 copayment when authorized by a WellCare physician.	Covered up to 30 days when admitted by a WellCare physician.

SECTION FOUR

ENROLLMENT

A. Cost to Enrollees

Under the City's Employee Benefits Program, the basic coverage under some of the health plans requires no member contribution, while others require a payroll or pension deduction. All plans, except for Med-Team, offer additional benefits through Optional Riders which may be purchased through payroll or pension deductions. Basic plan and Optional Rider costs are shown on pages 44 & 45 of this booklet.

Under the voluntary Medical Spending Conversion (MSC) Program, health plan deductions will be made on a pre-tax basis beginning October 1, 1991. While this is meant to save employees money, employees do have the option of declining this benefit. (See Section One, Recent Benefit Changes).

B. Eligibility

1. Employees

You are eligible for health coverage and you may enroll in the Employee Benefits Program if:

- a. You work—on a regular schedule—at least 20 hours per week;
and
- b. Your appointment is expected to last for more than six months.

2. Retirees

You are eligible for health coverage and you may enroll in the Employee Benefits Program when you retire if:

- a. You have at least five years of credited service as a member of an approved pension system (this requirement does not apply if you retire because of accidental disability);
and
- b. You have been employed by the City (or City-related or City-approved agency) prior to retirement and have worked regularly for at least 20 hours per week;
and
- c. You receive a pension check from a retirement system maintained by the City or another system approved by the City.

NOTE: Various pension systems have different eligibility rules; consult your agency's or institution's personnel office for details.

3. Dependents Eligible for Enrollment

- a. Legally married husband or wife. An ex-spouse is never eligible for coverage under the Employee Benefits Program regardless of the provisions of any legal settlement.
- b. Unmarried children under age 19. The term "children" for purposes of this and the following definitions, includes: natural children; children for whom a court has

accepted a consent to adopt and for the support of whom an employee or retiree has entered into an agreement; children for whom a court of law has made an employee or retiree legally responsible for support and maintenance; and children who live with an employee or retiree in a regular parent/child relationship and are supported by the employee or retiree.

- c. Unmarried dependent children age 19 to 23 who are full-time students.* However, Empire Blue Cross and Blue Shield hospital coverage for full-time students is available only through the Optional Rider under GHI-CBP/EBCBS, and is not available under GHI Type C/EBCBS. In addition, as of January 1, 1992, GHI medical coverage for full-time students under GHI-CBP/EBCBS will only be available through the Optional Rider.
- d. Unmarried children age 19 and over who cannot support themselves because of mental illness, developmental disability, mental retardation, or physical handicap, if the disability occurred before the age at which coverage would otherwise terminate, and the dependent was covered by the City at that time. You must provide medical evidence of the disability to your health plan within 31 days of the date the dependent reaches the age limitation. Contact your health plan or agency personnel or payroll office for the forms which must be completed for continuation of coverage.

4. Double City Coverage Is Not Permitted

You cannot be covered by two health contracts for which the City pays or to which the City contributes.

If you are eligible for coverage as an employee or retiree AND as a dependent (of another City employee or retiree), you may enroll as an employee (or retiree) or as a dependent, but not both. Eligible dependent children must all be enrolled as dependents of one parent.

If both husband and wife are eligible for City health coverage as either employees or retirees and one is enrolled as the dependent of the other, the person enrolled as a dependent may pick up coverage, at any time, in his or her own name if the other contract is terminated for any reason.

C. How To Enroll

1. As an Employee

To enroll, you must obtain and file an Employee Health Benefits Application (Form EB 88) at your payroll or personnel office. The form must be filed within 31 days of your appointment date (for exceptions, see Section E.). If you do not file the form on time, the start of your coverage will be delayed and you may be subject to loss of benefits.

*Empire Blue Cross and Blue Shield HEALTHNET, Mid-Hudson Health Plan and WellCare provide full-time student coverage to age 25.

2. As a Retiree—at Retirement

You must file a Retiree Health Benefits Application (Form P2r) at your payroll or personnel office prior to retirement to continue your coverage into retirement.

3. After Retirement

To enroll, you must obtain a Retiree Health Benefits Application (Form P2r) from the Employee Benefits Program. Complete the form and file it with the Employee Benefits Program. You must meet the eligibility requirements described in this booklet. If you are retired from a cultural institution, library, or the Fashion Institute of Technology, or if you receive a TIAA/CREF pension and are eligible for City health coverage, you must file a Retiree Health Benefits Application (Form P2r) with your former employer.

4. Deferred Retirement

If you have retired but will not receive a City pension check until age 55, you may be eligible for up to an additional five years of City-paid health coverage. As the result of a collective bargaining agreement, retirees who are members of the New York City Employees' Retirement System—Pension Plan A—or the Board of Education Retirement System and have had at least 20 years of credited service are eligible for five years of additional City coverage. Please contact your payroll or personnel office for details.

D. Waiver of Health Benefits

If you are already enrolled for City health benefits in any other capacity (for example, as a dependent), or if you do not want City health coverage, you must waive membership in the Employee Benefits Program by completing the appropriate sections of the Employee Health Benefits Application (Form EB 88). Retirees may waive membership by completing the appropriate sections of the Retiree Health Benefits Application (Form P2r). Every eligible employee or retiree must either enroll for coverage or waive membership.

If you have waived membership and subsequently wish to enroll for City health plan coverage, you may be subject to a waiting period. (see E.6 below.)

E. Effective Dates of Coverage

1. When Coverage Begins for Employees

For Provisional employees, Temporary employees, and those Non-Competitive employees for whom there is no experience or education requirement for employment, coverage begins on the first day of the pay period following the completion of 90 days of continuous employment, provided that your Application (Form EB 88) has been submitted within that period.

2. For All Other Employees

For employees appointed from Civil Service-eligible lists, Exempt employees, and those Non-Competitive employees for whom there is an experience or education requirement,

coverage begins on your appointment date, provided your Application Form (Form EB 88) has been received by your agency personnel or payroll office within 31 days of that date.

3. For Eligible Dependents

Coverage for eligible dependents listed on your Application (Form EB 88) will begin on the day that you become covered.

Dependents acquired after you submit your Application (Form EB 88) as a result of marriage, birth, or adoption, will be covered from the date of marriage, birth or adoption, provided that you submit the required notification and documentation within 31 days of the event. (See Changes in Family Status, page 36).

4. Late Enrollment

For employees and their dependents, filing an application later than 31 days after the date of the marriage, birth, etc. constitutes a late enrollment. Coverage will begin on the first day of the payroll period following the receipt of the application by the agency payroll or personnel office.

5. When Coverage Begins for Retirees

If you file the Retiree Health Benefits Application (Form P2r) for continuation of coverage into retirement with your agency payroll or personnel office prior to retirement (usually 4 to 6 weeks), for most retirees, coverage begins on the day of retirement (See F., Identification Cards).

6. If you have waived or cancelled your City health plan coverage and subsequently wish to enroll or reinstate your benefits, your coverage will not start until the beginning of the first payroll period 90 days following the date you submit your Application (Form EB88 or P2r), unless the enrollment or reinstatement is the result of a loss of other group coverage.

F. Identification Cards

When you first enroll under the Program, whenever there is a change in family status (for example, from individual to family), when you transfer from one plan to another, or when you retire, your health plan(s) will issue new identification cards.

Group Health Incorporated/Empire Blue Cross and Blue Shield subscribers (GHI Type C/EBCBS or GHI-CBP/EBCBS) will receive two identification cards, a GHI card and an Empire Blue Cross and Blue Shield card. The EBCBS card should be used for hospital admissions or emergency room visits, and the GHI card should be used for physician or other medical services.

If you do not receive a new identification card from your health plan within three months after submitting an Application (Form EB 88 or P2r), you should notify your agency payroll or personnel office. If you are a retiree, write to the Employee Benefits Program (See Section Two).

Between submission of a retirement application and the issuance of the new identification cards, retirees may receive

cancellation notices and notice of direct payment options from the plan. You should ignore this mailing, as it is due to a routine delay in updating computer files to reflect retirement status.

If the retiree or any of his/her dependents, enrolled in an HMO, need services and the identification cards have not been issued, the retiree should present the retiree copy of the Application (Form P2r) to the physician as proof of enrollment. If the retiree belongs to an indemnity program, claims should be held and submitted after the identification cards are received. If hospitalized, the retiree should contact his/her health plan or the Employee Benefits Program for assistance.

G. Optional Riders

All but one of the health plans have an Optional Rider consisting of benefits which are not part of the basic plan. You may elect Optional Rider coverage when you enroll. Optional Riders are paid for through payroll or pension deductions. The cost of these riders can be found on pages 44 and 45.

Many employees and retirees get additional health benefits through their welfare funds. If you are enrolled in GHI-CBP/EBCBS, GHI Type C/EBCBS, HIP/HMO*, Metropolitan Health Plan, or Med Plan, and your welfare fund is providing benefits similar to some (or all) of the benefits in your plan's Optional Rider, those specific benefits will be provided only by your welfare fund and will not be available through your health plan rider. Pension and payroll deductions will be adjusted accordingly. Each rider is a package. You may not select individual benefits in the rider.

The Optional Rider for Empire Blue Cross and Blue Shield HEALTHNET, HIP CHOICE, WellCare, Mid-Hudson Health Plan, US HEALTHCARE, Sanus and CIGNA HEALTHPLAN consists of a prescription drug plan. If your union welfare fund provides prescription drug benefits, do not choose the Optional Rider on these plans. Payroll or pension deductions will not be adjusted automatically to account for union welfare fund benefits.

H. Deductions for Basic Coverage and Optional Riders

1. From Paychecks

If there is a payroll deduction for your plan's basic coverage, or if you apply for an Optional Rider, your paycheck should show a deduction for this cost. If your check does not reflect the deduction within two months after submitting a new Application (Form EB 88), or if your deductions are not correct, you must notify your personnel or payroll office.

2. From Pension Checks

It may take considerable time before health plan deductions start from retirees' pension checks. A large retroactive deduction is then made to pay for coverage during the period from retirement to the time of the first deduction.

*If you or your dependents are covered by HIP VIP and other dependents on the plan are not Medicare-eligible, and your union welfare fund provides prescription drug benefits, you do not need to choose Optional Rider coverage. Benefits for appliances and private-duty nursing will be provided to the non-Medicare eligible person at no cost.

When retirees in the New York City Employees' Retirement System receive their first full pension allowance checks, their pension numbers change. Because of this, deductions will stop for three to five months and will begin again when the new numbers have been processed. Health coverage is continuous throughout this period. When deductions resume, they will include back charges for months when deductions were not taken. Contact the New York City Employee Benefits Program if deductions are incorrect. When either you or a dependent becomes eligible for Medicare (by reaching age 65 OR through disability), the amount deducted is adjusted after you notify the Employee Benefits Program of Medicare coverage. (See Section Eight). This adjustment may also take time to be recorded.

3. Incorrect Deductions

If incorrect deductions are being taken from your payroll or pension checks, report the error promptly. Employees should contact their agency benefits representative and retirees should contact the Employee Benefits Program. Corrections will be made as quickly as possible after notification.

SECTION FIVE

CHANGES IN ENROLLMENT STATUS

A. Changes in Family Status

Changes in your family status may make it necessary, or desirable, for you to change your type of coverage. Changes in coverage do not happen automatically. You must submit a form requesting the type of change you wish to make. Employees may obtain an Employee Health Benefits Application (Form EB 88) and submit the completed form to their personnel or payroll office. Retirees should obtain a Retiree Health Benefits Application (Form P2r) and submit the completed form to the Employee Benefits Program.

1. Adding or Dropping Dependents

You must complete a form to add dependents due to marriage, birth or adoption of a child, and to drop dependents due to death, divorce, or a child reaching an ineligible age.** Employees should complete an Employee Health Benefits Application (Form EB 88) and retirees should complete a Retiree Health Benefits Application (Form P2r). Forms should be submitted within 31 days of the event. (Late enrollment: see Section Four, E. 4.) Appropriate documentation of marital status, or birth or adoption of a child is required. This documentation may consist of marriage, birth, or baptismal certificates; adoption or guardianship papers; or copies of tax returns indicating a child is claimed as a dependent.

**If a covered dependent loses eligibility, that person may obtain benefits through the COBRA Extension of Benefits provisions described in Section Seven, B, of this booklet.

2. Child Reaching Age 19 or Age 23

Under a family contract, unmarried dependent children are covered to age 19. Unmarried dependent children age 19 to 23 who are full-time students are routinely covered under all plans except for the two GHI/EBCBS plans. Empire Blue Cross and Blue Shield hospital coverage for full-time students is available only through the Optional Rider under GHI-CBP/EBCBS, and is not available on the GHI Type C/EBCBS. As of January 1, 1992, GHI medical coverage for full-time students will only be available through the Optional Rider under GHI-CBP/EBCBS. Coverage for full-time students up to age 25 is provided by Empire Blue Cross and Blue Shield HEALTHNET, Mid-Hudson Health Plan, and WellCare. (See Section Four, B. 3. d. for special provisions for disabled children.)

B. Change in Plan

1. Annual Transfer Period

Health Benefits Transfer Periods (Open Enrollments) are usually scheduled once each year. During these periods, all employees may transfer from their current health plan to any other plan for which they are eligible, or they may add Optional Rider coverage to their present plan. Retirees participate in Transfer Periods that occur in even-numbered years.

If you do not apply for an Optional Rider when you first enroll, you may add these additional benefits only during a Transfer Period, upon retirement, or if there is a change in your union or welfare fund coverage.

NOTE: The 1991 Transfer Period will take place from October 1 to October 31, 1991, and will be open to all employees.

All transfer applications must be submitted by October 31, 1991.

Procedures for Employee Health Plan Transfers

In order to transfer from one plan to another or to add Optional Rider coverage, you must complete an Employee Health Benefits Application (Form EB 88), which is available from your agency payroll or personnel office (refer to pages 4 and 5 for the agency listings). This form must be completed and returned to your payroll or personnel office during the annual Transfer Period.

See your agency payroll or personnel office for the effective date of the change. Once you submit an Application (Form EB 88), the Transfer Period is over for you and your transfer is irrevocable.

2. Retiree Transfer Opportunities

As a result of collective bargaining, retirees may transfer or add an Optional Rider during the even-numbered year Transfer Periods. Additionally, retirees may transfer or add an optional rider once in their lifetime, at any time after they have been retired for at least one year. Once-in-a-

lifetime transfers become effective on the first of the month following the date that the retiree signs the Retiree Health Benefits Application.*

C. Transfer Into or Out of Your Health Plan's Service Area

If you permanently move outside of your plan's service area, you may transfer within 31 days to another plan without waiting for the next transfer period. Also, if you move into the service area of a plan, you may transfer within 31 days to that plan.*

D. Special Leave of Absence Coverage (SLOAC)

Certain employees on maternity or authorized leave without pay as a result of temporary disability or illness, military leave, or who are receiving Workers' Compensation, may have their City health coverage continued for certain specified periods of time through the Special Leave of Absence Coverage (SLOAC) provisions. Contact your payroll or personnel office for details.

E. Change of Address

If you change your address be sure to notify your health plan by telephone or writing so that your records can be kept up-to-date. Always provide your certificate or identification number when communicating with health plans.

Retirees should notify the Employee Benefits Program of any address change.

F. Transfer From One City Agency to Another

If you leave the employment of one City agency at which you are covered under the City Employee Benefits Program, and subsequently become employed by another City agency at which you are eligible to enroll for health coverage, your coverage will become effective on your appointment date at the new agency, provided that no more than 90 days have elapsed since your coverage terminated at the first agency. Your new agency should reinstate your coverage by submitting a completed Employee Health Benefits Application (Form EB 88), See Section Six, B. You may only change health plans during the annual Transfer Period.

If more than 90 days have elapsed, the rules specified in Section Four of this booklet apply. You must complete a new Employee Health Benefits Application (Form EB 88).

G. Change of Union or Welfare Fund Membership

Title changes that result in a change of union or welfare fund membership may require a change in payroll deductions for any Optional Rider coverage. You should contact your agency benefits representative if you have changed unions or welfare funds.

*Exception: When transferring into the Medicare Risk Plans (HIP VIP, CIGNA HEALTHPLAN, and US HEALTHCARE) transfers will become effective on the first day of the second month following the date of authorization indicated on the Form P2r. (For example, if the P2r is completed in August, the effective date would be October 1.)

SECTION SIX

TERMINATION AND REINSTATEMENT

A. When Coverage Terminates

Coverage terminates:

1. for an employee or retiree and covered dependents, when the employee or retiree stops receiving a paycheck or pension check (with an exception for people eligible for SLOAC).
2. for a spouse, when divorced from an employee or retiree.
3. for a child, upon marriage or reaching an ineligible age, except for unmarried dependent full-time students who are covered on all plans** up to age 23 or 25. (See Section Four, B.3. d. for special provisions for disabled children who reach age 19, 23 or 25.)
4. for all dependents, unless otherwise eligible, when the City employee or retiree dies.

If both husband and wife are eligible for City health coverage as either an employee or a retiree, and one is enrolled as the dependent of the other, the person enrolled as dependent may pick up coverage in his/her own name if the spouse leaves City employment or dies.

B. Reinstatement of Coverage

If you have been on approved leave without pay, or have been removed from active pay status for any other reason, your health coverage may have been interrupted.

Contact your agency benefits representative within 31 days of your return to duty in order to complete a new Employee Health Benefits Application (Form EB 88). If you are returning from an approved leave of absence or your coverage has been terminated for less than 90 days, coverage resumes on the date you return to duty. If you were not on an approved leave of absence or if your coverage has been terminated for more than 90 days, the effective date rules specified in Section Four of this booklet apply.

If you have waived or cancelled your City health plan coverage and subsequently wish to enroll or reinstate your benefits, your coverage will not start until the beginning of the first payroll period 90 days following the date you submit your Application (Form EB88 or P2r) unless the enrollment or reinstatement is the result of a loss of other group coverage.

**Empire Blue Cross and Blue Shield hospital coverage is available only through the Optional Rider under GHI-CBP/EBCBS, and is not available under GHI Type C/EBCBS. As of January 1, 1992, GHI medical coverage for full-time students will only be available through the Optional Rider under GHI-CBP/EBCBS.

SECTION SEVEN

OPTIONS AVAILABLE WHEN CITY COVERAGE TERMINATES

A. Conversion Options

Employees and/or their spouses and covered dependents may purchase health coverage through their plan on an individual, self-paid basis when coverage under the City's group plan ceases. Unlike COBRA (discussed in "B" below), benefits under this type of policy do not automatically terminate after a limited time, and may vary from the City's "basic" benefits package in both the scope of benefits and in cost.

An employee, his/her spouse, and covered dependents may convert to a direct-payment policy when coverage under the City's group plan ceases for any of the following reasons:

1. an employee leaves City employment;
2. an employee loses City coverage due to a reduction in the work schedule;
3. the employee/retiree dies;
4. a dependent spouse is divorced from the employee/retiree;
5. dependent children exceed the age limits established under the group contract; or
6. coverage under the provisions of COBRA expires. (See "B" below for further information.)

An individual electing conversion must notify the health plan of his/her request for such coverage within 45 days of termination of coverage under the City's group plan.

For further information on the scope and cost of benefits available, please contact your current health plan.

B. COBRA Continuation Benefits

The Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-2721, Title X), also known as COBRA, was enacted by Congress on April 7, 1986 and implemented by the City of New York on July 1, 1987.

The law requires that the City and union welfare funds offer employees, retirees and their families the opportunity to continue group health and/or welfare fund coverage in certain instances where the coverage would otherwise terminate. The monthly premium will be 102% of the group rate (or 150% of the group rate for the 19th through 29th months in cases of total disability—see B.2). All group health benefits, including Optional Riders, are available. Welfare fund benefits which can be continued under COBRA are dental, vision, prescription drug, and other related medical benefits. The maximum period of coverage is 18, 29, or 36 months, depending on the reason for continuation.

As a result of collective bargaining agreements, Medicare-eligible enrollees and/or their Medicare-eligible dependents are being offered continuation benefits similar to COBRA if a COBRA event should occur. (SEE MEDICARE-ELIGIBLES.)

Laid-off Employees

Under a recent change in policy, laid-off City employees may now choose to continue coverage under any health plan offered by the City, for which they are eligible, as well as from several new COBRA options called COBRA Alternative Plans.

The COBRA Alternative Plans are designed to offer protection against medical and hospital bills but at a reduced level of benefits and at a reduction in costs. However, there are no optional riders available under the COBRA Alternative Plans and these plans are not available to Medicare-eligibles.

Information concerning COBRA and the new COBRA Alternative Plans will be in the COBRA packet you receive from your agency when you leave City employment.

1. Eligibility

Employees Not Eligible for Medicare

Employees of the City of New York are eligible for continuation under COBRA if their health and welfare fund coverages are terminated due to a reduction in hours of employment or termination of employment (for reasons other than gross misconduct). Termination of employment includes unpaid leaves of absence of any kind.

Spouses Not Eligible for Medicare

Spouses of employees (or retirees) have the right to choose continuation of coverage if they lose coverage for any of the following reasons: 1) death of the City employee or retiree; 2) termination of the employee's City employment (for reasons other than gross misconduct); 3) loss of health coverage due to a reduction in employee's hours of employment; 4) divorce from the City employee (or retiree); 5) retirement of the employee. (See Retirees below.)

Dependent Children Not Eligible for Medicare

Dependent children of employees (or retirees) have the right to continue coverage if coverage is lost for any of the following reasons: 1) death of a covered parent (the City employee or retiree); 2) the termination of a covered parent's employment (for reasons other than gross misconduct); 3) loss of health coverage due to the covered parent's reduction in hours of employment; 4) the dependent ceases to be a "dependent child" under the terms of the Employee Benefits Program; 5) retirement of the covered parent. (See Retirees below.)

Retirees

If you retire from the City, receive a pension check from a City-approved retirement system, have five years of credited service and have worked regularly at least 20 hours per week, you and your dependents are eligible to receive City-paid health care coverage. If you do not meet these requirements, you are not eligible to receive City-paid health care coverage, but you and your dependents (if not Medicare-eligible) may continue under COBRA the benefits you received as an active employee, for a period of 18 months at 102% of the group cost. If you are eligible for Medicare, see the Medicare-eligible section below.

If your welfare fund benefits are reduced or eliminated at retirement, you are eligible to continue those benefits that

were reduced under the welfare fund as a COBRA enrollee for a period of 18 months at 102% of the cost to the union welfare fund. You should contact your union welfare fund for the premium amounts and benefits available. A list of welfare fund administrators can be obtained from your payroll or personnel office.

NOTE: Individuals covered under another group plan are not eligible for COBRA continuation benefits unless the other group plan contains a pre-existing condition exclusion. However, these people may be able to purchase certain welfare fund benefits. For more information, contact the appropriate fund.

Medicare-Eligibles

Those employees, retirees, spouses and dependents who are eligible for Medicare may be eligible to receive continued coverage, similar to COBRA, under the City's Medicare-Supplemental plans. Periods of eligibility shall date from the original qualifying event up to 18 months in the case of loss of coverage because of termination of employment or reduction in hours, or up to 36 months in the case of loss of coverage for all other reasons.

If a COBRA qualifying event occurs and you lose coverage, but you and/or your dependents are Medicare-eligible, you may continue coverage by using the COBRA Continuation of Coverage application form. You should indicate your Medicare claim number and effective dates where indicated on the form for Medicare-eligible family members. If you and/or your dependents are about to become eligible for Medicare, and are already continuing coverage under COBRA, inform your health plan of Medicare eligibility for you and/or your dependents at least 30 days prior to date of Medicare eligibility. COBRA-enrolled dependents of the person who becomes Medicare-eligible will be able to continue their COBRA coverage, whether or not the Medicare-eligible person enrolls in the Medicare-Supplemental coverage. The COBRA continuation period for dependents will be unaffected by the decision of the Medicare-eligible employee or retiree.

NOTE: You should contact your health plan for information about other Medicare-Supplemental plans which are offered; some other plans may be better suited to your needs and/or less costly than the plan which is provided under the City's contract.

2. Periods of Continuation

Continuation of coverage for the former employee, retiree, family, or individual dependent as a result of termination of employment (for reasons other than gross misconduct), reduction of work schedule, or loss of welfare fund benefits due to retirement is available for a maximum period of 18 months. This period will be measured from the loss of coverage.

Effective July 1, 1990, if the employee is totally disabled on the date of termination from employment or reduction of hours, continuation of coverage may be extended from 18 to 29 months. The monthly premium for the 19th through 29th month will be 150% of the group rate. To qualify for 29 months of COBRA continuation coverage, Social Security must determine that the employee is totally disabled. If

Social Security later determines that the individual is no longer totally disabled, COBRA continuation coverage may terminate before the end of the 29th month.

Continuation of coverage for a spouse or dependents as a result of the death, divorce, or loss of coverage due to Medicare-eligibility of the contract holder, or loss of dependent child status, is available for a maximum of 36 months.

Continuation of coverage can never exceed 36 months in total, regardless of the number of events which relate to a loss in coverage. Coverage during the continuation period will terminate if the enrollee fails to make timely premium payments or becomes enrolled in another group health plan (unless the new plan contains a pre-existing condition exclusion).

3. Notification Responsibilities

Under the law, the employee or family member has the responsibility of notifying the City agency payroll or personnel office and the applicable welfare fund within 60 days of the death, divorce, or change of address of an employee, or of a child's losing dependent status. Retirees and/or the family members must notify the Employee Benefits Program and the applicable welfare fund within 60 days in the case of death of the retiree or the occurrence of any of the events mentioned above.

Effective July 1, 1990, employees who are totally disabled (as determined by Social Security) on the date of termination of employment or reduction of hours must notify their health plan of the disability. The notice must be provided within 60 days of Social Security's determination and before the end of the 18-month continuation period. If Social Security ever determines that the individual is no longer disabled, the former employee must also notify their health plan of this. This notice must be provided within 30 days from Social Security's final determination.

When a qualifying event (such as an employee's death, termination of employment, or reduction in hours) occurs, you and your family will receive a COBRA information packet from your City agency describing your option to choose continuation coverage.

4. Transfer Opportunities

Former employees and dependents who elect COBRA continuation coverage are entitled to the same benefits and rights as employees. Therefore, COBRA enrollees may take part in the annual Transfer Period. Dependents of retirees enrolled in COBRA continuation coverage will continue to receive the same transfer opportunities available to retirees: once-in-a-lifetime transfer (if not already used), and transfer during the normal Transfer Period for retirees.

Individuals eligible for COBRA may also transfer when a change of address allows or eliminates access to a health plan which requires particular Zip Code residency for eligibility.

Application forms to be used during the Transfer Period should be obtained from the COBRA enrollee's current health plan. Applications should be returned to the current health plan which will forward enrollment information to the new

plan. Be sure to elect a primary care physician for each family member if selecting an HMO that requires you to do so. These transfers will become effective on January 1, 1992.

City agencies will not in any way handle COBRA enrollee transfers, nor will they process any future changes such as adding dependents. All future transactions will be handled by the health plan in which the person eligible for COBRA is enrolled.

5. Election of COBRA Continuation

To elect COBRA continuation of health coverage, the eligible person must complete a "COBRA - Continuation of Coverage Application". Employees and/or eligible family members can obtain application forms from their agency payroll or personnel office. Retirees' eligible family members can obtain application forms by contacting the Employee Benefits Program. Please contact the applicable welfare fund if you wish to purchase its benefits.

Eligible persons electing COBRA continuation coverage must do so within 60 days of the date on which they receive notification of their rights, and must pay the initial premium within 45 days of their election. Premium payments will be made on a monthly basis. Payments after the initial payment will have a 30-day grace period.

C. New York State Six-Month Extension

The New York State Six-Month Extension applies only to those to whom COBRA is not available (for example, those terminated for gross misconduct) who were hired on or after January 1, 1986.

Employees terminated for reasons of gross misconduct can elect to continue coverage for a period of up to six months on a self-paid basis at a cost of 100% of the group rate.

To elect coverage under the Six-Month Extension, a terminated employee must complete a Six-Month Extension Application (Form EB 6) and return the appropriate copies to the health plan along with the first premium payment within 31 days of termination. Payments for the extension of coverage are made monthly, and for the GHI/EBCBS plans, each plan is paid separately for the coverage it provides. (GHI provides medical coverage and Empire Blue Cross and Blue Shield provides hospital coverage.)

D. Disability Benefits

If on the date of termination you are totally disabled as a result of an injury or illness, you remain covered with respect to your disability up to a maximum of 18 additional months for the GHI-CBP/EBCBS plan and up to 12 months for the HMO plans. GHI Type C/EBCBS provides only 31 days of additional coverage. This extension of benefits applies only to the disabled person and only covers the disabling condition. Under the GHI plans, if a subscriber is hospitalized at the time of termination, hospital coverage (under Blue Cross) is extended only to the end of the hospitalization. Contact your health plan for details.

SECTION EIGHT

CITY COVERAGE FOR MEDICARE-ELIGIBLE RETIREES

(This does not apply to **employees** over age 65.
See Section Nine.)

When you or one of your dependents becomes eligible for Medicare at age 65 (and thereafter) or through special provisions of the Social Security Act for the Disabled, your first level of health benefits is provided by Medicare. The Employee Benefits Program provides a second level of benefits intended to fill certain gaps in Medicare coverage. In order to maintain maximum health benefits, it is essential that you join Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) at your local Social Security Office as soon as you are eligible. If you do not join Medicare, you will lose whatever benefits Medicare would have provided; the City's Employee Benefits Program supplements Medicare but does not duplicate benefits available under Medicare. Medicare-eligibles must be enrolled in Medicare Parts A and B in order to be covered by Med-Team, Empire Blue Cross and Blue Shield HEALTHNET, US HEALTHCARE, CIGNA HEALTHPLAN, WellCare, Mid-Hudson, or Sanus. Medicare-eligible retirees enrolled in HIP/HMO must maintain Medicare Part B coverage, or they will lose their HIP/HMO membership. Medicare-eligibles may not be enrolled in Med Plan or Metropolitan Health Plan. If covered by HIP VIP, CIGNA HEALTHPLAN*, or US HEALTHCARE**, Medicare-eligible members will not receive health benefits from Medicare if care is received outside of their plans.

A. Medicare Enrollment (Retirees Only)

To enroll in Medicare and assure continuity of benefits upon becoming age 65, contact your Social Security Office during the three-month period before your 65th birthday.

In order not to lose benefits, you must enroll in Medicare during this period even if you will not be receiving a Social Security check.

If you are over 65 or eligible for Medicare due to disability and did not join Medicare, contact your Social Security Office to find out when you may join. If you do not join Medicare Part B when you first become eligible, there is a ten percent premium penalty for each year you were eligible but did not enroll. In addition, under certain circumstances there may be up to a fifteen-month delay before your Part B coverage can begin upon re-enrollment.

If you or your spouse are **INELIGIBLE** for Medicare Part A or Parts A and B, although over age 65 (reasons for ineligibility include non-citizenship or residence outside of the U.S.A. or its territories for Parts A and B, or non-eligibility for Social Security benefits for Part A), apply to:

N.Y.C. Employee Benefits Program
40 Rector Street—3rd Floor
New York, NY 10006

A policy for those not eligible for Medicare can be provided under certain health plans. Under a Non-Medicare Eligible Policy, you will continue to receive the same hospital and/or medical benefits as persons not yet age 65.

Please provide full identifying information, including name, date of birth, address, agency from which retired, pension number, health plan and certificate numbers, health code, Social Security Number and Medicare claim number (if any). Also give the reason for ineligibility for Medicare Part A and/or Part B.

If you are eligible for Medicare Part B as a retiree but neglect to file with the Social Security Office during their enrollment period (January through March) or prior to your 65th birthday, you will receive supplemental medical coverage only, and only through GHI/EBCBS Senior Care. You cannot receive the non-Medicare eligible policy.

B. Notification to the Employee Benefits Program and Health Plans

You must notify the Employee Benefits Program in writing immediately upon receipt of your or your dependent's Medicare card. Include the following information: a copy of the Medicare card and birthdates for yourself and spouse, retirement date, pension number and pension system, name of health plan, and name of union welfare fund. In some cases, the Employee Benefits Program or your health plan may contact you requesting some of this information. Once the Employee Benefits Program is notified that you are covered by Medicare, deductions from your pension check will be adjusted, if applicable, and you will automatically receive the annual Medicare Part B premium reimbursement (See C., Medicare Premium Reimbursement). The Employee Benefits Program will notify your health plan that you are enrolled in Medicare so that your benefits can be adjusted. This may take several months. If your plan does not accept Medicare-eligibles, you will receive special instructions concerning changing to another health plan.

C. Medicare Premium Reimbursement

The City will reimburse you for a portion of the monthly premium for Medicare Part B for yourself and your spouse and dependents enrolled on Medicare disability.

Periodically, the Medicare Part B premium is increased by the Social Security Administration. At the time of each increase, legislation must be approved by the City Council authorizing the City to reimburse you at a new rate. The reimbursement rate for 1990 is \$27.90 per month.

If you are receiving a Social Security check, the premium for Medicare Part B will be deducted from that check monthly. If you are not receiving a Social Security check, you will be billed on a quarterly basis by the Social Security Administration. You must be receiving a City pension check and be enrolled as the contract holder for City health benefits in order to receive reimbursement for Part B premiums. For most retirees, the refund is issued automatically by the Employee Benefits Program, 40 Rector Street, 3rd Floor, New York, NY 10006, telephone (212) 513-0470. Medicare Part B reimbursement checks are generally issued once a year in the summer following the year in which premiums are paid.

*CIGNA HEALTHPLAN applies only to New York residents.

**US HEALTHCARE applies only to New York and Pennsylvania residents.

SECTION NINE

SPECIAL PROVISIONS FOR MEDICARE-ELIGIBLE EMPLOYEES

The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, the Deficit Reduction Act of 1984 (DEFRA), the Consolidated Omnibus Budget Reconciliation Acts of 1985 (COBRA) and 1986, and the Omnibus Budget Reconciliation Act of 1986 (OBRA) enacted by the Federal Government, contain provisions that directly affect your City group health benefits.

These laws require the City of New York to offer all employees or their dependents over age 65 or covered by Medicare through the Special Provisions of the Social Security Act for the Disabled* the same health coverage offered to employees not yet age 65 and under the same conditions. Your City health plan will automatically become your primary coverage and Medicare will provide secondary coverage.

If you wish Medicare to be your primary coverage, you are not eligible for the City's group health plan. You must complete the waiver section of the Employee Health Benefits Application (Form EB 88) and return it to your agency payroll or personnel office.

A. Retirement

At retirement, employees who have chosen Medicare as their primary plan or whose dependents have not been covered on their plan because their spouse elected Medicare as the primary plan may re-enroll in the City health program. This is done by completing a Retiree Health Benefits Application (Form P2r) and submitting it to their payroll or personnel office.

Also at retirement, employees for whom the City health plan had provided primary coverage for Medicare-eligibles are permitted to change health plans effective on the same date as their retiree health coverage.

B. Medicare Premium Reimbursement

Employees and their dependents covered by Medicare have identical benefits to those provided to employees and their dependents under age 65. Because of the cost of these benefits, the City does not reimburse employees or dependents for their Medicare Part B premiums if the City health plan is primary. (Employees or their dependents who elect Medicare as their primary coverage and waive or cancel City health plan benefits are entitled to reimbursement of Medicare Part B premiums.)

Medicare premium reimbursement will be available at retirement when Medicare becomes the primary plan.

C. Medicare Enrollment

Medicare Medical Insurance (Part B) is voluntary with a monthly premium which is subject to change. If you and/or your dependents choose City health coverage as primary, Medicare will be supplementary to any City health plan.

*The rules are somewhat different for persons eligible for Medicare due to end-stage renal disease. Consult your Medicare Handbook or agency health benefits representative for further information.

There are no penalties for late enrollment in Medicare Part B if employees choose the Employee Health Benefits Program as primary coverage and cancel or delay enrollment in Medicare Part B coverage until retirement or termination of employment, when Medicare enrollment is permitted for a limited period of time. Medicare Hospital Insurance (Part A) should be maintained. For most persons, Part A coverage is free.

SECTION TEN

COORDINATION OF BENEFITS (COB)

A. General

You may be covered by two or more group health benefit programs, which may provide similar benefits. Should you have services covered by more than one program, your City health plan will coordinate benefit payments with the other program. One program will pay its full benefit as a primary insurer, and the other program will pay secondary benefits. This prevents duplicate payments and overpayments. In no event shall payments exceed 100% of a charge.

The City program follows certain rules which have been established to determine which program is primary; these rules apply whether or not you make a claim under both programs.

B. Rules of Coordination

The rules for determining primary and secondary benefits are as follows:

1. The program covering you as an employee is primary before a program covering you as a dependent.
2. When two plans cover the same child as a dependent, the child's coverage will be as follows:
 - The plan of the parent whose birthday falls earlier in the year provides primary coverage.
 - If both parents have the same birthday, the plan which has been in effect the longest is primary.
 - If the other plan has a gender rule (stating that the plan covering you as a dependent of a male employee is primary before a plan covering you as a dependent of a female employee), the rule of the other plan will determine which plan will cover the child. (See "C" below for special rules concerning dependents of separated or divorced parents.)
3. If no other criteria apply, the program covering you the longest is primary. However, the program covering you as a laid-off or retired employee, or as a dependent of such a person, shall be secondary, and the program covering you as an active employee shall be primary, as long as the other program has a COB provision similar to this one.

C. Special Rules for Dependents of Separated or Divorced Parents

If two or more plans cover a dependent child of divorced or separated parents, benefits are to be determined in the following order:

1. The plan of the parent who has custody of the child is primary.
2. If the parent with custody of a dependent child remarries, that parent's program is primary. The step-parent's program is secondary and the program covering the parent without custody is tertiary (third).
3. If the specific decree of the court states one parent is responsible for the health care of the child, the benefits of that plan are determined first. You must provide the appropriate plan with a copy of the portion of the court order showing responsibility for health care expenses of the child.

D. Effect of Primary and Secondary Benefits

1. Benefits under a program that is primary are calculated as though other coverage did not exist.
2. Benefits under a program that is secondary are calculated based upon the difference between what the primary program paid and 100% of the actual charge. The amount paid may not exceed the amount that would have been paid in the absence of other coverage.

SECTION ELEVEN

NO-FAULT EXCLUSION

The Employee Benefits Program will not provide benefits for any services for which benefits are available under a No-Fault Automobile Policy.

SECTION TWELVE

EMPLOYEE ASSISTANCE PROGRAMS (EAP)

The City of New York's network of Employee Assistance Programs (EAPs) is staffed by professional counselors who can help employees and their eligible dependents handle an array of problems such as stress, alcoholism, drug abuse, and family problems.

An EAP will provide education, information, counseling and individualized referrals to assist with a wide range of personal or social problems. If you don't have an EAP in your own agency or union, you can get help at the Central Employee Assistance Program. The Program is located at 40 Rector Street, 7th Floor, New York, NY 10006. Telephone number is (212) 306-7660.

The City of New York's Central Employee Assistance Program gives you free, personal and quick access to referrals for professional help. An employee's contact with this service is private, privileged and strictly confidential. No information will be shared with anyone at any time without your written consent.

Prior to using outpatient services for drug abuse, all subscribers, except for employees of the Police and Correction Departments and employees in the Probation Officer title series, should contact their agencies' EAPs for appropriate case review, referral, and follow-up. Employees of the Police and Correction Departments and those in the Probation Officer title series cannot use their agencies' EAPs or the Central EAP if they wish to use the outpatient drug benefit, but instead may self-refer to outpatient treatment facilities until further notice.

SECTION THIRTEEN

THE EMPLOYEE BLOOD PROGRAM

Your health plan covers the cost of administering transfusions and pays blood processing fees for employees, retirees and eligible family members. It does not pay for the storage of your own blood for future use.

Blood replacement fees are not covered by any health plan offered by the City. However, under the blood supply system introduced in 1980, hospitals in the Greater New York region generally have access to sufficient voluntarily donated blood and therefore do not bill for replacement fees. The Greater New York region comprises New York City, Long Island, nearby counties in upstate New York, and some parts of northern New Jersey. Outside that area, many hospitals are still charging for blood that is not replaced.

To help our community maintain the blood reserves required to avoid resumption of replacement fees, the Employee Blood Program sponsors a voluntary donor program for City employees, called the City Donor Corps. City Donor Corps members who donate once a year are entitled to certain benefits for themselves and family members. For further information, see your agency Blood Program Coordinator, or call (212) 566-2800.

SECTION FOURTEEN

BASIC PLAN AND OPTIONAL RIDER COSTS

Basic coverage is available at no cost to the subscriber under certain plans, while other plans require a payroll or pension deduction. A rider for optional benefits may be purchased under all but one of the plans (Med-Team does not offer an optional rider).

Under the voluntary Medical Spending Conversion (MSC) Program (see page 2), health plan deductions will be made on a pre-tax basis beginning October 1, 1991. While this is meant to save employees money, employees do have the option of declining this benefit.

Each rider is a package. You may not select individual benefits in the rider. However, if your union welfare fund provides benefits similar to some or all of those listed in the rider for your plan, those specific benefits will be provided only by your welfare fund and will not be available through the health plan rider. In these cases payroll and pension deductions will be reduced accordingly.

(NOTE: If your health plan's optional rider only consists of a prescription drug plan and your welfare fund provides this same benefit, do not choose the rider, because deductions will not be adjusted.)

These rates are in effect as of July 1, 1991, and are subject to change.

	COSTS									
	Monthly		Bi-Weekly		Semi-Monthly		Weekly		Monthly	
	Individual	Family	Individual	Family	Individual	Family	Individual	Family	Medicare Eligible Retirees (per person)	
GHI-CBP/EMPIRE BLUE CROSS BLUE SHIELD BASIC PLAN	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	
OPTIONAL RIDER GHI Prescription & Maintenance Drugs	\$19.51	\$ 35.74	\$ 8.98	\$16.45	\$ 9.76	\$17.87	\$ 4.49	\$ 8.23	\$43.42	
365-Day EBCBS Hospitalization	\$ 6.81	\$ 15.87	\$ 3.13	\$ 7.30	\$ 3.41	\$ 7.94	\$ 1.57	\$ 3.65	\$ 3.68	
\$500 Maximum Coinsurance (GHI Benefit)	\$ 2.37	\$ 5.09	\$ 1.09	\$ 2.34	\$ 1.19	\$ 2.55	\$ 0.55	\$ 1.17	Not Available	
EBCBS Inpatient Substance Abuse Treatment	\$ 2.30	\$ 4.88	\$ 1.06	\$ 2.25	\$ 1.15	\$ 2.44	\$ 0.53	\$ 1.12	Not Available	
GHI Outpatient Psychiatric Care	\$ 3.62	\$ 5.58	\$ 1.67	\$ 2.57	\$ 1.81	\$ 2.79	\$ 0.83	\$ 1.28	Not Available	
Full-time students to age 23 EBCBS Hospital Coverage	-0-	\$ 3.00	-0-	\$ 1.38	-0-	\$ 1.50	-0-	\$ 0.69	Not Available	
GHI Medical Coverage, effective Jan. 1992	-0-	\$ 3.81	-0-	\$ 1.75	-0-	\$ 1.91	-0-	\$ 0.88	Not Available	
Enhanced GHI NYC Non-Participating Provider Reimbursement Schedule	\$ 5.68	\$ 15.36	\$ 2.61	\$ 7.07	\$ 2.84	\$ 7.68	\$ 1.31	\$ 3.53	Not Available	
TOTAL	\$40.29	\$ 89.33	\$18.54	\$41.11	\$20.16	\$44.68	\$ 9.28	\$20.55	\$47.10	
GHI TYPE C/EMPIRE BLUE CROSS AND BLUE SHIELD BASIC PLAN	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	
OPTIONAL RIDER GHI Prescription & Maintenance Drugs	\$19.51	\$ 35.74	\$ 8.98	\$16.45	\$ 9.76	\$17.87	\$ 4.49	\$ 8.23	\$43.42	
365-Day EBCBS Hospitalization	\$ 6.81	\$ 15.87	\$ 3.13	\$ 7.30	\$ 3.41	\$ 7.94	\$ 1.57	\$ 3.65	\$ 3.68	
TOTAL	\$26.32	\$ 51.61	\$12.11	\$23.75	\$13.17	\$25.81	\$ 6.06	\$11.88	\$47.10	
EBCBS HEALTHNET BASIC PLAN	\$57.20	\$141.07	\$26.33	\$64.93	\$28.60	\$70.54	\$13.16	\$32.47	\$53.73	
OPTIONAL RIDER Prescription Drugs	\$ 9.63	\$ 20.74	\$ 4.43	\$ 9.55	\$ 4.82	\$10.37	\$ 2.22	\$ 4.77	\$28.88	
TOTAL	\$66.83	\$161.81	\$30.76	\$74.48	\$33.42	\$80.91	\$15.38	\$37.24	\$82.61	
									MCP	VIP
HIP/HMO BASIC PLAN	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
OPTIONAL RIDER Prescription Drugs	\$18.48	\$ 46.22	\$ 8.51	\$21.27	\$ 9.24	\$23.11	\$ 4.25	\$10.64	\$38.53	Covered in basic
Appliances and Private Duty Nursing	\$ 1.02	\$ 2.54	\$ 0.47	\$ 1.17	\$ 0.51	\$ 1.27	\$ 0.23	\$ 0.58	Covered in basic	Covered in basic
TOTAL	\$19.50	\$ 48.76	\$ 8.98	\$22.44	\$ 9.75	\$24.38	\$ 4.48	\$11.22	\$38.53	-0-
HIP CHOICE BASIC PLAN	\$25.94	\$ 64.84	\$11.94	\$29.85	\$12.97	\$32.42	\$ 5.97	\$14.92	-0-	-0-
OPTIONAL RIDER Prescription Drugs	\$18.48	\$ 46.22	\$ 8.51	\$21.27	\$ 9.24	\$23.11	\$ 4.25	\$10.64	\$44.88	Covered in basic
TOTAL	\$44.42	\$111.06	\$20.45	\$51.12	\$22.21	\$55.53	\$10.22	\$25.56	\$44.88	-0-

	COSTS									
	Monthly		Bi-Weekly		Semi-Monthly		Weekly		Monthly	
	Individual	Family	Individual	Family	Individual	Family	Individual	Family	Medicare Eligible Retirees (per person)	
MED PLAN BASIC PLAN	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	Not Available	
OPTIONAL RIDER Prescription Drugs	\$18.48	\$ 46.22	\$ 8.51	\$21.27	\$ 9.24	\$23.11	\$ 4.25	\$10.64	Not Available	
Appliances and Private Duty Nursing	\$ 1.02	\$ 2.54	\$ 0.47	\$ 1.17	\$ 0.51	\$ 1.27	\$ 0.23	\$ 0.58	Not Available	
TOTAL	\$19.50	\$ 48.76	\$ 8.98	\$22.44	\$ 9.75	\$24.38	\$ 4.48	\$11.22		
MED-TEAM BASIC PLAN (No Rider Available)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	
CIGNA HEALTHPLAN* BASIC PLAN	\$ 1.33	\$ 25.87	\$ 0.61	\$11.91	\$ 0.67	\$12.94	\$ 0.31	\$ 5.95	-0-	
OPTIONAL RIDER Prescription Drugs	\$ 8.98	\$ 24.62	\$ 4.14	\$11.33	\$ 4.49	\$12.31	\$ 2.06	\$ 5.67	Covered in basic	
TOTAL	\$10.31	\$ 50.49	\$ 4.75	\$23.24	\$ 5.16	\$25.25	\$ 2.37	\$11.62		
METROPOLITAN HEALTH PLAN BASIC PLAN	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	Not Available	
OPTIONAL RIDER Prescription Drugs	\$18.48	\$ 46.22	\$ 8.51	\$21.27	\$ 9.24	\$23.11	\$ 4.25	\$10.64	Not Available	
Appliances and Private Duty Nursing	\$ 1.02	\$ 2.54	\$ 0.47	\$ 1.17	\$ 0.51	\$ 1.27	\$ 0.23	\$ 0.58	Not Available	
TOTAL	\$19.50	\$ 48.76	\$ 8.98	\$22.44	\$ 9.75	\$24.38	\$ 4.48	\$11.22		
MID-HUDSON HEALTH PLAN BASIC PLAN	\$14.31	\$ 48.31	\$ 6.59	\$22.24	\$ 7.16	\$24.16	\$ 3.29	\$11.12	\$ 9.22	
OPTIONAL RIDER Prescription Drugs	\$11.38	\$ 29.59	\$ 5.23	\$13.62	\$ 5.69	\$14.79	\$ 2.62	\$ 6.81	Covered in basic	
TOTAL	\$25.69	\$ 77.90	\$11.82	\$35.86	\$12.85	\$38.95	\$ 5.91	\$17.93	\$ 9.22	
SANUS HEALTH PLAN BASIC PLAN	\$11.68	\$ 17.94	\$ 5.38	\$ 8.26	\$ 5.84	\$ 8.97	\$ 2.69	\$ 4.13	\$42.39	
OPTIONAL RIDER Prescription and Maintenance Drugs	\$ 5.70	\$ 15.39	\$ 2.62	\$ 7.08	\$ 2.85	\$ 7.70	\$ 1.31	\$ 3.54	\$35.86	
TOTAL	\$17.38	\$ 33.33	\$ 8.00	\$15.34	\$ 8.69	\$16.67	\$ 4.00	\$ 7.67	\$78.25	
									Risk Plan	Premier Plan
US HEALTHCARE BASIC PLAN	\$10.98	\$ 19.49	\$ 5.05	\$ 8.97	\$ 5.49	\$ 9.75	\$ 2.53	\$ 4.49	-0-	\$79.77
OPTIONAL RIDER Prescription Drugs	\$12.40	\$ 30.20	\$ 5.71	\$13.90	\$ 6.20	\$15.10	\$ 2.85	\$ 6.95	\$70.90	\$15.80
TOTAL	\$23.38	\$ 49.69	\$10.76	\$22.87	\$11.69	\$24.85	\$ 5.38	\$11.44	\$70.90	\$95.57
WELLCARE OF NEW YORK BASIC PLAN	\$20.07	\$ 63.22	\$ 9.24	\$29.10	\$10.04	\$31.61	\$ 4.62	\$14.55	\$ 9.22	
OPTIONAL RIDER Prescription Drugs	\$11.21	\$ 29.15	\$ 5.16	\$13.42	\$ 5.60	\$14.58	\$ 2.58	\$ 6.71	Covered in basic	
TOTAL	\$31.28	\$ 92.37	\$14.40	\$42.52	\$15.64	\$46.19	\$ 7.20	\$21.26	\$ 9.22	

*California rates may differ. See page 6.

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